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Euthanasia: Understanding Ethical Issues through Role-Play

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EUTHANASIA: UNDERSTANDING ETHICAL ISSUES THROUGH ROLE-PLAY

A Synthesis Project Presented

by

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ABSTRACT

EUTHANASIA: UNDERSTANDING ETHICAL ISSUES THROUGH ROLE-PLAY

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Having transformed traditional ethics, people have empowered themselves and put ethics under their control. An individual's value has become the center of all decision making. Where has ethics gone? Why has ethics been fossilized? When an individual desperately needs a *litmus test* to check his stance, why cannot he re-visit ethics and apply its insights to solving his problems? I wish to believe that there might be a legacy of conventional ethics in the form of universal rules, regardless of time, culture, and context, to be passed on to the next generation. Has God given us life, death, and choice of life? Has God also given us the ability to understand another person's pain? If so, we need to be conscientious about what is an *appropriate way* to resolve problems along with multi-disciplinary approaches in the postmodern world.

How much has ethics tried to adapt to current science/technology? Has ethics offered us any appropriate way of dealing with what's right and/or wrong or with alternatives, whenever we are in the midst of complicated problems? When did we begin to omit ethics in our decision making process? Ethics seems not to be the sole value, but it has to compete with other contemporary values.

The presently burning issue called *euthanasia* is everyone's business, one we all have to face. I wonder if death is part of God's purpose for lives or a divine appointment. The conundrum intertwined with euthanasia relates to how to reach a satisfactory end of life backed up by ethics. Critical and Creative Thinking could help us go through the crux of the issue and mold an individual's ethical decision, while maintaining a balance with social justice.

My goal in this synthesis paper is two fold: to provide a theoretical description of euthanasia and to prepare English teaching materials for Japanese college students on reading comprehension, by garnering the latest news/research from leading newspapers, periodicals, and the internet, and role play to help exchange views, to share empathy and I hope to create a climate of mutual trust among participants by the time role-play reaches its debriefing session.

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CHAPTER I.

INTRODUCTION

I find myself standing at a point in 1999 trying to see the reality of end of life issues as an overture to the question why I cannot ignore ethical aspects of euthanasia. Chapter I is on the status of euthanasia in 1999. This includes three main situations in which euthanasia is practiced and ethical issues which are derived from and/or satisfy our own value systems in terms of medical/legal aspects, and alternatives. Chapter II discusses how humans historically treated ethical issues by applying the golden rule and considers major philosophers, such as, Plato, Thomas Aquinas, Montaigne, Kant, and others. VanDeVeer and Regan suggest that we value bioethics or medical ethics which is different from contemporary popular approaches taken by both pro and/or con euthanasia advocates. Singer has developed his idea along with utilitarianism and animal welfare. Chapter III scrutinizes the crux of three moral issues: autonomy, best interest, and sanctity of life, to reach a major philosophical problem: Which comes first *ends* or *means* in the case of euthanasia? Chapter IV deals with medical/care issues: How should physicians and medical-health professionals inquire before assisting suicide? What is the cause and definition of death based on medical viewpoints? And how can patients be empowered in their treatment in a hospital or a hospice? Chapter V touches on legalization of euthanasia with the consideration of its merits and demerits. Chapter VI explains about teaching materials developed for college students in Tokyo, Japan, with the emphasis on the following two aspects: (1) reading comprehension of the latest newspapers,

periodicals, and/or the Internet followed by discussion in a whole class on euthanasia and (2) role-playing to develop an open discussion and then to share empathy, and finally to build mutual trust among the participants in a role-play. Chapter VII talks about implications for the future in which the climate of euthanasia is subject to change along with people's shifting interpretations in relation to other numerous factors, particularly, medical/legal issues and alternatives. Both content and context of either reading materials or role-playing will be revised to suit students' needs.

1.1 How many main situations are there in euthanasia?

"What is life?" a priest in London asked church members. He then clapped his hands. "Is that true?" again he shouted. One of the elder members agreed by nodding her head down and I was one of them. If life is just like *a second* as he wisely demonstrated, we really need to contemplate how to choose to die. Let's face the reality. Sooner or later, we must find our own *silver linings* on the verge of life and death. Based on Dworkin (1993), the following three main situations are alternatives: First, *conscious and competent persons* who want to control their treatment and death. A detailed suicide manual by Derek Humphry called *Final Exit* (1991) contributed to heightening public interest. Second, *Unconscious persons* who are in comas and persistent vegetative states and who cannot communicate about/or decide their own death. For example, Karen Quinlan collapsed on April 15th, 1975 and lived until 1985 in a persistent vegetative state.

Third, *Conscious but incompetent persons*, i.e., Alzheimer's disease patients who are not competent to determine their own death.

My view is that doctors do not have the right answer to the question of "Why must we die?" Who would determine when lives are not worth living or when the burden of life is too great to be borne? At this stage, doctors and the patient stand at the same level, because no special insights have been given from their training to become physicians.

1.2 What are ethical aspects of euthanasia?

How can we define freedom in terms of the right to die and the right to live? If freedom is a continuum, one extreme end would be freedom to live, whereas, the other extreme end would be freedom to die. If so, where is euthanasia located in the continuum? I wonder if it could be every where in the continuum depending on an individual's choice. Euthanasia offers us a question of choice, or it empowers us to demonstrate our deepest self once we happen to face ultimate reality. I believe to empower means to superficially make us control and/or satisfy our feelings at the corner just before turning to death. However, in reality we are defeated/eroded by diseases and have lost our last hope at that literally dead-end-corner and have found ourselves with no way out, except for euthanasia. I believe the ultimate and most crucial problem of euthanasia which is intertwined with not only ethical, but also medical, legal, and other related issues is "When should the decision about the end of life be made and who should make it, based on what sorts of ethical points of view?"

Ethical issues about medical aspects include: (1) Where is the line drawn between not being kept alive and being killed? (2) What are the risks that people will ask to be killed after a misdiagnosis? (3) Would doctors who help us to die, even though with the best motives, grow more **in**sensitive or numb whenever they face patients' agonizing with pain, or would they be less careful or less zealous about saving lives? (4) How should patient's family members ask a doctor to know how much pain the patient actually has? (5) How should patients' family members educate themselves on their loved one's various kinds of pain, i.e., physical pain, psychological pain, and cultural pain to be able to communicate with doctors? And (6) should doctors' training be changed to include end-of-life treatment, particularly, pain management, how to narrow the gap of communication between a doctor and a patient and his family members on the patient's treatment, while a doctor tries to develop mutual trust, how to utilize the content of a patient's living will for a doctor's daily contact with the patient, and how to relate the ethics of medicine to the present law and guidelines for future treatment?

Ethical problems about legal aspects are: (1) Do Americans have a constitutional right to die? (2) Must states honor living wills? (3) Which decision is the right one to make legally no matter who makes it? (4) If a patient can *not* make a decision, how do we know how the patient wants to be treated, in case of facing loss of dignity? (5) Is it legitimate to take the family's wishes into account separately from the patient? (6) Who should make life-or-death decisions for the sake of patients? (7) What are safeguards/formal requirements about when and

how to die before making decisions? (8) If the decisions are made, who should review them with fairness/impartiality? (9) If legally sanctioned killing were permitted, would the community as a whole become more callous, lacking pity or mercy, with no feelings about death? And (10) has euthanasia *hastened* mercy-killing in the Netherlands through a slippery slope process?

Ethical aspects of alternatives include: (1) how to prepare a living will, (2) how to think about palliative care (hospice care), and (3) how to find other doctors before choosing euthanasia.

Ethical/moral aspects involving family members include: (1) How can the balance of health be kept between a patient and the exhausted patient's family members? (2) How could family members mitigate their *guilt feelings* if they had to decide on euthanasia due to their loved one's being terminally ill and in an unconscious state? (3) Is euthanasia a personal matter confined only to an individual or a family, or a social Issue requiring legal steps prior to actually doing euthanasia? (4) How can family members construct mutual trust with the doctor in charge of their loved one in order to enable the patient to get better treatment? And (5) which books should patients' family members read to fully understand the patient's diseases, pain, medical problems, care issues, law, financial matters, alternatives, and foreseeable situations?

Ethics, one way or another, relates to all facets of multi-layered euthanasia. People in all walks of life facing euthanasia have to ponder how ethics would function before making their decisions. Let's consider past ethical behavior to gain an insight into humans' behavior in the present and the years to come.

CHAPTER II.

ETHICAL HISTORY

In order to grasp the year 1999 as a part of long history of ethics, I look back on the trend of ethics from ancient times. "Where has the traditional ethics of which our great grandparents used to be proud *gone*?" is my question, because all values seem mixed up in the 1990's because no priority exists. Bioethics has been generating a new wave by throwing a creative and critical ball into the following two fields: (1) traditional ethics is becoming the view of a minority and (2) the growing popularity of atheists, anti-religious movements or secular cultures. Is there any ultimate ethics which can conquer the recently popular *relativism*? With that kind of characteristic attached, can we still call it a universal ethics? As humans are social animals, what could we learn from other animals' behaviors? This is an interesting question with which to wind up this chapter.

2.1 When did people start thinking of euthanasia?

The changing meaning/interpretation and application of euthanasia illustrate human beings' ultimate desire to control an ***un****controllable* object: Death. Euthanasia, derived from *good death* (***eu*** means *good* plus ***thanatos*** as *death*) in Greek, meant to bring about a gentle and easy death. Nowadays, it means the action to induce and/or kill incurably ill patients with great pain. Since the fifth century B.C., euthanasia has been rejected by physicians when they first took the Oath of Hippocrates and swore "To give no deadly medicine to anyone if

asked, nor suggest any such counsel." This evidence shows that people even in ancient times thought about how to apply euthanasia.

2.2 How does the golden rule relate to euthanasia?

Historically, philosophers and moralists used the Golden Rule and Christian commandments as the bases of western ethics. In *Sophie's World* by Gaarder (1996), Socrates was guided by a divine inner voice and this conscience told him what was right. "He who knows what good is will do good" (1996: 69) is based on his rationalism. Plato quoted by Bowie, et.al., (1996: 473-476) stated that (1) Soul, the invisible part, divine, immortal, and wise, makes its way to a region of the same kind, noble and pure, and truly spends the rest of time with the gods. (2) Shadowy phantoms and images which are not the souls of good but of inferior men, have been visible, though not purifying the souls. (3) Those who have esteemed injustice highly will join the tribes of wolves and hawks, whereas, those who have practiced popular and social virtue with moderation and justice will join a social and gentle group, i.e., bees or wasps. (4) No one may join the company of the gods who has not practiced philosophy and is not completely pure when he departs from life, no one but the lovers of learning. (5) As philosophy gets hold of the souls of the lovers of learning, they understand that they cannot trust only what they see through the eyes. (6) Genuine lovers of learning are moderate and brave. And (7) the soul of the philosopher achieves a calm from such emotions like Penelope at her web. Plato, according to Gaarder (1996), contemplated the relationship between what is eternal and immutable and what

"flows" (1996: 82). Plato believed in the existence of eternal and absolute rules for what was right or wrong. By using our common sense we can all arrive at these immutable norms, since human reason is in fact eternal and immutable (1996: 83). I think Plato believes humans' common sense is a good means to separate "What was right" from "What was wrong." Plato was concerned with: (1) what is eternal and immutable in nature *and* (2) what is eternal and immutable as regards to morals and society. To Plato, these two problems were one and the same. He tried to grasp a "reality" that was eternal and immutable (1996: 83). Plato believed that everything tangible in nature *flows*. So there are no substances that do not dissolve (1996: 83). Plato's conception was of eternal and immutable patterns, spiritual and abstract in their nature, that all things are fashioned after (1996: 84). Plato came to the conclusion that there must be a reality behind the material world. He called this reality *the world of ideas*; it contained the eternal and immutable patterns behind the various phenomena we come across in nature. This remarkable view is known as Plato's theory of ideas. (1996: 85). Plato presented a picture of the ideal state, or an imaginary, ideal or a Utopian state, in *The Myth of the Cave* found in his dialogue, *The Republic*. Plato believed the ideal state should be (1) governed by philosophers and (2) based on the construction of the human body. I believe his theory should be seated as a foundation of thinking, regardless of the contents of any subjects.

The significance of *The Myth of the Cave* is as follows: firstly, the only thing the cave dwellers can see is the shadow play, and secondly, imagine one of the cave dwellers manages to free himself from his bonds, and ask, "Where do all

these shadows on the cave wall come from?" and "Where do all the animals and flowers come from?" What Plato was illustrating in *the Myth of the Cave* is the philosopher's road from shadowy images to the true ideas behind all natural phenomena. *The Myth of the Cave* illustrates Socrates's courage and his sense of pedagogic responsibility. Therefore, the story helps succinctly distinguish between our illusion coming from our eyes and Plato's world of ideas. The relationship between the darkness of the cave and the world beyond corresponds to the relationship between the forms of the natural world and the world of ideas. Not that he meant that the natural world is dark and dreary, but that it is dark and dreary in comparison with the clarity of ideas (1996: 90).

Historically speaking, there are two distinguished figures who discussed life and death issues from totally different perspectives. One is Thomas Aquinas and the other is Michel de Montaigne. Thomas Aquinas (circa 1225-1274) condemned all suicide because of (1) its violating human's natural desire to live, (2) its bringing harms to other people, and (3) not being acceptable to take life which is the gift of God, or only God can take that role. Michel de Montaigne (1533-1592), the first major dissenter among European writers, considered *suicide* as a *personal choice,* helping open up discussion of a rational alternative. Kant, a most zealous Christian, abided by the moral law and developed his formula: Act only on that maxim through which you can at the same time will that it should become a universal law. R.M. Hare modified Kant's theory and claimed *universalizability* as a logical feature of moral judgments. Utilitarians, Jeremy Bentham to J. J. C. Smart, decided moral issues as "each counts for one and

none for more than one." John Rawls, a contemporary leading critic of utilitarianism, developed his own ethical thought derived from basic ethical principles. Even Jean-Paul Sartre, an existentialist who came to Tokyo where I had a chance to directly listen to his lecture, and the Marxist, Habermas, admit that ethics has universal characteristics.

2.3 Is ethics universal or impartial nature?

Kohlberg (1983: 56) states the following Seven Phases of the collective norm: Phase 1 is *Collective norm proposal* (Individuals propose collective norms for group acceptance); Phases 2 and 3 are called *Collective norm acceptance* broken down into: Phase 2 of Collective norms accepted as a group ideal but not agreed to, and Phase 3 of Collective norms accepted and agreed to but not yet acknowledged as expectations for behavior; Phases 4 and 5 are called *Collective norm expectation* divided into: Phase 4 of Collective norms accepted and expected (naïve expectation), and Phase 5 of Collective norms expected but not followed (disappointed expectation); and Phases 6 and 7 are *Collective norm enforcement* separated between Phase 6 of Collective norms expected/upheld through expected persuading and Phase 7 of Collective norms expected/upheld through expected reporting of deviant to the group. Regarding Phases of the degree of community valuing, the following four stages were mentioned by Kohlberg (1983: 67) using a school's example: Phase 1: Instrumental extrinsic in which the school is valued as an institution helping individuals meet his/her own academic needs; Phase 2: Esprit de corps's extrinsic where the school helps

individuals feel some loyalty toward the school as manifested in team spirit and support of teams/groups in school; Phase 3: Spontaneous community intrinsic that the school is the place members feel an inner motivation to help others in the group community generating special feelings/closeness among members; and Phase 4: Communal intrinsic on which the school-oriented community is based for its own sake obligating its members in special privilege or responsibilities from the group and other members. The above descriptions are self-explanatory showing how member-based ethics is embedded in a community's culture whenever more than two people happen to get together at a place for pursuing a certain common goal.

Skinner states below (1971: 128):

> What a given group of people calls good is a fact, it is what members of the group find reinforcing as a result of their genetic endowment and the natural and social contingencies to which they have been exposed. Each culture has it own set of goods, and what is good in one culture may not be good in another.

His claim, "What is good in one culture may not be good in another," allows us to consider *relativism* which causes cannibalism to be moral right in a cannibalistic society. To avoid the above mentioned tendency, I wish to refer to Kohlberg's moral elements and norms below (1983: 96-97) to pave the way to the ideal of fairness. Kohlberg's elements include: Upholding normative order, Obeying (consulting): person or deity, Blaming (approving), Retributing (exonerating), Having a right and/or no right, Having a duty and/or no duty; egoistic consequences (good and/or bad reputation and seeking reward or avoiding punishment); utilitarian consequences (good and/or bad individual consequences

and good and/or bad group consequences); ideal or harmony serving consequences (upholding character, upholding self-respect, serving social ideal or harmony, and serving human dignity and autonomy); and *fairness* (balancing perspectives or role-taking, reciprocity or positive desert, maintaining equity/ procedural fairness, and maintaining social contract or freely agreeing). Pertaining to *The Norms*, Kohlberg (1983: 96) lists up 12 items below: Life (Preservation, and quality/quantity), Property, Truth, Affiliation, (Erotic love and sex), Authority, Law, Contract, Civil rights, Religion, Conscience, and Punishment. My question is where euthanasia-related ethics should be located within Kohlberg's various measures. No set answers are anticipated, because, I think, even on the same question, i.e., What is unusual treatment?, people, depending on various reasons, i.e., his/her profession, interests, and schema (background knowledge), would answer differently. Nowadays, each individual in the U.S., regardless of social status, seems to enjoy creating his or her own idiosyncratic meaning of ethics against traditional norms, like Mr. Clinton. Since I came from a high context culture in which children are expected to acquire traditional norms from their parents and then apply them without fail, I often cannot fully understand why Mr. Smith or Ms. Jones thinks in a certain way.

Concerning T.S. Eliot's notion of *interpretation* through which the world would be evaluated by either God or Mammon written in his Doctoral Dissertation to Harvard called *Knowledge and Experience*, Kearns (1994:91) claims Eliot requested us to reinterpret every thinking mind and every civilization, because

even the finest tact can give us only an interpretation. I guess Eliot appeared to urge us to be cautious about all our traditionally accepted interpretations/norms.

Singer states (1979:11) one thing in common among so far mentioned utilitarians, existentialists, and marxists is: justification of an ethical principle cannot be in terms of any partial or sectional group. Ethics takes a universal point of view. In other words, ethics requires us to go beyond *my or your* interest to the universal law, or the universal judgment as an impartial/ideal observer. Having said ethical judgments must be constructed on a universal point of view, Singer recommends to us the universal aspect-oriented ethics applied in our daily ethical decision making to guide us to a broader sense of utilitarianism. In comparison with the classic utilitarianism of Bentham and John Stuart Mill who applied pleasure and pain for achieving what one desired as a pleasure, as opposed to a pain, contemporary utilitarianism measures all interests in order to increase pleasure and to reduce pain and then makes the best decision which surely would bring the maximum benefit as the consequences to those who are involved.

2.4 Where has traditional ethics gone?

Bradley (originally 1876, reprinted in1962: 61-63) who loved virtue for her own sake stated people misunderstand ethics to vindicate their self-interest:

> What answer can we give when the question Why should I be Moral?, in the sense of What will it advantage Me?, is put to us? Here we shall do well, I think, to avoid all praises of the pleasantness of virtue. We may believe that it transcends all possible delights of vice, but it would be well to remember that we desert a moral point of view, that we degrade and prostitute virtue, when to those who do not love her for herself we

bring ourselves to recommend her for the sake of her pleasures.

As the characteristics of our postmodern or post Christian society, Anderson (1990: 6) claims the following three issues: (1) the breakdown of old ways of belief as Yeats once wrote in *The Second Coming*, (2) the emergence of a new polarization, a conflict about the nature of social truth itself; epistemology joins the old family favorites – class, race, and nationality, and (3) the birth of a global culture with truly a *world*view where everyone struggles in unprecedented ways to find out who and what s/he is. Here is the first part of Yeats' *The Second Coming* (1924:187):

> Turning and turning in the widening gyre. The falcon cannot hear the falconer; Things fall apart; the centre cannot hold; Mere anarchy is loosed upon the world. The blood-dimmed tide is loosed, and everywhere. The ceremony of innocence is drowned; The best lack all conviction, while the worst are full of passionate intensity.

I wonder whether or not traditional ethics should catch up with and/or adjust itself to the ever changing nature of humanity's value systems. Now, let's focus on current bioethics which relates to contemporary euthanasia-based decision making.

2.5 How has bioethics affected current ethics?

Pertaining to the contribution of bioethics to end of life decisions, VanDeVeer and Regan (1987) believe, because of recent remarkable advance in medicine, euthanasia is currently one of the most complex problems. They also believe the opposition to euthanasia (doctors ought not to let people die if their lives can possibly be saved) is wrong in three fundamental moral principles: mercy,

autonomy, and justice. For granting a person a humane and merciful death, they propose the following safer way to determine our moral duties than sticking to physician-initiated euthanasia.

The mercy issue on euthanasia: The principle of mercy should be as follows: (1987: 101):

> It asserts that where possible, one ought to relieve the pain or suffering of another person, when it does not contravene that person's wishes, where one can do so without undue costs of oneself, where one will not violate other moral obligations, where the pain or suffering itself is not necessary for the sufferer's attainment of some overriding good, and where the pain or suffering can be relieved without precluding the sufferer's attainment of some overriding good.

The principle of medical mercy consists of the following two factors which relate most heavily to the duty of physicians and nurses (1987: 102).

1. the duty not to cause further pain or suffering; and
2. the duty to act to end pain or suffering already occurring.

Mercy requires a physician not to impose the debridement treatment. On the other hand, attempts at resuscitation would be permitted by the principle of medical mercy in the case where there is some chance of survival with good recovery predicted. The principle of medical mercy demands the following elements: (1) to impose suffering on a patient without overriding benefits for the patient ought not be done; (2) not merely extending the patient's life without both (a) reducing pain and (b) providing pain-free life with independent normal life; (3) no treatment allowing a patient to die, if death cannot be any worse than what the patient experiences now; (4) to act to end suffering that is already occurring as medicine on pain management has managed this duty; (5) to allow to die in

passive euthanasia; and (6) to kill to directly ease pain in active euthanasia. On the relationship between passive/active euthanasia and pain, VanDeVeer and Regan (1987: 104) state:

> Although it may be possible to draw a conceptual distinction between passive and active euthanasia, this provides no warrant for the ubiquitous view that killing is morally worse than letting die. Nor does it support the view that withdrawing treatment is worse than withholding it. If the patient's condition is so tragic that continuing life brings only pain, and there is no other way to relieve the pain than by death, then the more merciful act is not one that merely removes support for bodily processes and waits for eventual death to ensue; rather it is one that brings the pain – and the patient's life – to an end *now.* If there are grounds on which it is merciful not to prolong life, then there are also grounds on which it is merciful to terminate it at once.

By referring to a pendulum which moves the same degree to both sides, I understand the above explanation. However, I personally need a long time to digest the above mentioned *termination* as merciful conduct. As mercy should be considered together with pain, I wish to think about pain control.

As pain control is still a *myth* because no pain control can completely remove pain, patients may be wrongly treated and caused/sedated into unconsciousness or hastened to death by depressing respiratory function. VanDeVeer and Regan (1987: 105) state:

> Although it is always technically possible to achieve relief from pain, at least when the appropriate resources are available, the price may be functionally and practically equivalent, at least from the patient's point of view, to death.

I believe the above statement makes room for different interpretations of euthanasia depending on real situations. The problem of physical pain is that *no* one can actually feel another's pain, and making the situation more difficult is that suffering involving no physical pain may be much harder to assess for family

members/friends. On the contrary, family members with strong emotional attachment cannot watch the patient and may suffer more than the patient. VanDeVeer and Regan (1987: 107) claim: (1) there is no objective way to establish how mercy should be taken in any specific case or how one should respond; (2) unless we accept a metaphysical assumption that life is a gift from God, we must recognize that life is a benefit; (3) the basic goods of life differ for individual persons; (4) unless pain and discomforting symptoms are gone without loss of function, the underlying problem for the principle of mercy remains; and (5) we need to ask "How does *this* patient value life, how does s/he weigh death against pain?"

Autonomy of euthanasia: Patient's autonomy supports euthanasia as the second principle stated below (1987: 107):

> One ought to respect a competent person's choices, where one can do so without undue costs to oneself, where doing so will not violate other moral obligations, and where these choices do not threaten harm to other persons or parties.

VanDeVeer and Regan (1987: 109) argue: (1) legal documents, i.e., living will or durable powers of attorney, are primarily to allow to die, not to be helped to die; (2) allowing to die is sometimes *less merciful* than direct, humane killing: the principle of mercy demands the right to be killed as well as to be allowed to die; (3) this principle should protect a patient's two kinds of rights as choices: (a) active means of death and (b) refusal of treatment; (4) in case of a doctor's wrong diagnosis, the cost of unnecessary death must be compared with dying in agony if the diagnosis is right, but no cure provided; (5) the hard paternalist may argue, because death is the greatest harm, euthanasia must always be thwarted;

(6) the principle of mercy obliges to relieve suffering when it does not serve some overriding good, but the principle cannot tell whether sheer existence or *life* is an overriding good; (7) without an objective and valid answer, we must appeal to the individual's subjective choice or preferences and values; (8) which is the greater evil: death or pain?; (9) Pope John Paul II stated "No one may ask to be killed," and Peter Williams claimed "A person does not have a right to be killed even though to kill him might be humane,"; both are wrong; (10) full autonomy is not achieved until one can both choose and act on one's choices; (11) a physician's obligation is both to make a patient act on his choice and to respect the patient's choice, by not causing the following situations: a person chooses death by active euthanasia without no information given by doctors and doctors' using euthanasia to vindicate their lukewarm treatment and/or without challenging medically difficult treatment which would make their patients comfortable.

Justice in euthanasia is the third moral principle with the question of How euthanasia has contributed to fairer distribution of limited medical resources in order to provide maximum cure for all. Based on each person's claim, we have an obligation to relieve the person's suffering. However, when there are insufficient medical resources, nobody feels satisfied with what s/he receives as treatment. As a result, we have to focus on a principle of distributive justice based on (1) medical needs, (2) restoration of function, (3) individual's payment, (4) social contributions, and (5) most deprived persons of medical care in the past. Under the principle of distributive justice, the dying will be allowed to die making resources be given to salvageable competitors for full health care,

because the principle of salvageability demands justice in a scarcity situation. Treatment should be provided by urgency/seriousness-based medical condition/judgment. If therapeutic treatment decreases, palliative care increases to apply the principle of mercy. Under the principle of justice, all parties in the distribution can have prima facie claims, but the weakest claim is from the dying. To allow a patient to die, without considering mercy or autonomy overriding the demands of justice in weighing claims, may cause enormous loss of money, scarce supplies, and/or caregiver time.

Contemporary euthanasia practices violate the principle of mercy in such cases as (1) permanently comatose/brain dead patients who do not suffer, so that we cannot say they are *better off* dead and (2) more than enough relief is given to suffering patients. We need to remember the principle of mercy demands euthanasia only when no other means of relieving pain will suffice. Doctors fail to acknowledge that continuous and very heavy use of narcotizing drugs may function equivalently to mercy killing. As conclusion, VanDeVeer and Regan claim prohibiting euthanasia is not the appropriate solution, but patients should be allowed to decide what is done for them by preparing living wills and other legal documents. As a realistic desire to improve the conditions of dying is required, mercy will not require euthanasia, or an autonomous person will not choose it, if dying conditions are humane like Hospice care; patient's own wishes and tolerance for pain should be highly considered for giving neither too little relief nor too much; and to broaden our scope of autonomy of dying, because a patient may want active means of end of life.

Singer argues (1979: 3): (1) Ethics is not a system of rules as the deontologists tried to find a hierarchy in which no conflict of rules exists. (2) Ethics is entirely independent of religion as Plato refuted a similar claim. Kant, though a Christian, argued to obey the moral law for its own sake, because the roots of ethics relate to most people's attitudes/sympathy for others, not religious thought. And (3) Ethics has the universal principle to make us think about happiness relating to suffering.

Singer (1979: 6) claims relativism cannot give satisfactory explanations for other ethical standards, or relativists only enjoy their own society's right. Relativism can share no basis to choose between conflicting views, or relativist-based analysis has no conflict. Singer's question (1979: 6) is "Does ethics have a role of reason and argument? Or is ethical reasoning possible as practical ethics on a sound basis?" Each person tells a lie and gives a reason for that action by justifying it as the right (or his self-interest alone) based on his own ethical standards. Singer defines ethics according to the universal principle, i.e., Do what increases happiness and reduces suffering or pain. As this expression lacks context, I think there is room for interpretation. Once we apply the universal principle to our real world, we tend to interpret the meaning to suit our own needs in the specific context. Or the principle is switched as *relative ethics* tailored to our own inner feelings. Take *slavery*, for example, a specific culture/situation may accept it by vindicating the upper class people's freedom as the right action, whereas, other cultures hate slavery because of not treating everyone equal. In our daily life, we know telling a lie is not good as the

universal principle, but we may tell a lie in a certain situation, like, "I love your present, thanks!" in order not to ruin our relationship with that person, instead of saying, "I hate your present," revealing our true feeling. Relativists always justify their idiosyncratic reasoning depending on context. Therefore, relativism cannot provide a satisfactory explanation for other ethical value-based people. Or the relativists' working area is limited only to the same value-shared territory.

In Australia and New Zealand, the arguments below have been developed on the subject of euthanasia: Dr. Brian Stoffell, head of the Medical Ethics Unit at the Flinders Medical Centre, as quoted by Burns and Hunt (1996), claims a capable philosopher attacks the inconsistencies of Anti-Assisted-Suicide/Euthanasia defender's deontological grounds, i.e., the notion that killing is wrong runs up against cases in which life lost may seem not worth sustaining. Dr. Roger Hunt, a caring palliative physician in the Southern Hospice Program at Daw Park Repatriation Hospital, as quoted by Burns and Hunt (1996), believes euthanasia is a proper part of the repertoire of hospice care. Dr. Al Vedig, head of the Intensive Care Unit at the Flinders Medical Centre, as quoted by Burns and Hunt (1996), observes that the extent of suffering will be influenced by quality of life issues. Dr. Margaret Otlowski, a lecturer in Law at the University of Tasmania, as quoted by Burns and Hunt (1996), claims that, to end the legal and moral problems rumored as many Australian doctors have hidden practices, the present law should be reformed to clear up the *gap* between current doctor-centered treatment in the real world and safeguards legally initiated for their practices. Professor Grant Gillett quoted by Burns and Hunt (1996), a New

Zealand neurosurgeon at Dunedin Hospital, mentions his experience in judgment to withdraw treatment when the sheer importance of what one was deciding about caused a hesitation in the decision. Even though virtue ethics is currently a significant minority in Australian bioethics, his approach allows to have a good casuist way of distinguishing killing and letting die, ordinary and extra-ordinary means, and/or double effect.

I wonder if analytical philosophy allows one to demonstrate current problems of distinctions between killing and letting die or ordinary and extra-ordinary means. In various social values and political processes caught up individual autonomy in death as a dominant value, bioethics appears to acknowledge, in order to let us live together, the importance of *collective decisions* of *altruism* situated beyond moral differences among people.

2.6 What can humans learn from animal altruism?

The universality of ethics leads us to equally treat other creatures in nature so that humans as social animals, are expected to focus on animal altruism. Wilson (1975: 595) in *Sociobiology: The New Synthesis* defined sociobiology as "the systematic study of the biological basis of all social behavior." Singer mentions human beings can learn from *animal altruism*, because other animals use the following strategies: (1) the warning call, (2) attacking/threatening predators to protect other members of their species, (3) sharing food, (4) helping injured animals survive, (5) restraint by animals in combat with their fellows, (6) reciprocating grooming group as an advantage as a group over another group,

and (7) the most obvious way in which evolution can produce altruism is the concern of parents for their children. *Reciprocal altruism* which looks like the social contract model of ethics is observed in monkeys' manner of "You scratch my back and I'll scratch yours." In humans' case, if I see a stranger drowning, I will jump in to save her. With my help, she will be saved. One day I will need to be rescued, and the person I saved this time may jump in and help me. If we practice reciprocal altruism, it pays to take part. Chances are you'll benefit later.

What is the link between rescuing a stranger and being rescued oneself? The sphere of altruism broadens to not only human beings, but also all beings. We must begin to design our culture so that broader concerns will be developed without limitation to human desires. Bioethics relates to other ethical and/or philosophical issues about euthanasia. Therefore, the next chapter will compare and/or analyze contemporary and controversial issues involved in the process of decision making about euthanasia.

CHAPTER III.

PHILOSOPHICAL ASPECTS

Why does euthanasia cause various problems in our decision making process? Because euthanasia at first makes us confront an unprecedented field of rights and/or obligations and secondly it forces us to go beyond our intellectual capacity. In order to clear up the complicated status of contemporary euthanasia, we need to analyze three moral principles: autonomy, best interest, and sanctity, together with the features of suicide attempts. Many issues ranging from the definition of death to the controversial discussion about *means* and *ends* relating deeply to the application of Active/Passive euthanasia are juxtaposed with an individual's various interests, concerns, and considerations.

3.1 Why have *three moral issues* always been interplaying?

Dworkin (1993) claims the following three euthanasia-related moral issues: autonomy, best interest, and sanctity:

First, autonomy: the right to die relates to autonomy. People's right means to make their own decision either to live or to die, such as, in *Jean's Way* who died on her own terms, not from the disease ravaging her body. Competent elderly patients in the Netherlands reported that they have begun to look on doctors as their enemies with their fear of being killed. Pro euthanasia individuals wishing to compromise their pain at the end of life with their pursuing dignity want to claim "Why do we prolong terminally ill patients' suffering? Legalized PAS would allow doctors to provide patients with such relief." Pro-euthanasia thinking is supported by (1) The Hemlock Society USA, (2)

Kevorkian, and (3) Derek Humphry. Koops (1989) thinks the right to die would lead us to the implication of the right of How-to-die. Koops questions the following points: (1) Does a patient have the right to anticipate a painless and comfortable death? (2) If a patient is terminally ill, who might take an active role in shortening the dying process for the patient's comfort? (3) If a patient wants a mercy killing, why should other people object? And (4) Is the use of any means justified to bring about a desired death? As a result, Koops believes that life and death are God's business.

Second, best interest: Provided someone voluntarily wants to die with his self-consciousness and genuine wish, people tend to oppose euthanasia/suicide on paternalistic grounds, because they believe dying is against his interests and assume the person attempted suicide as the poor victim of his idiosyncratic prison because of that person's blindness to his own interests. Therefore, paternalistic people want to save the person's life by saying, "Listen! We do know better than you on what should be chosen for your interest."

Third, sanctity: Euthanasia violates the intrinsic value and sanctity of human life. John Locke, the 17th century British philosopher opposed suicide, because a human life is the property of God, not of the person or just a tenant temporarily living that life. Based on his idea, euthanasia was seen as an insult to God's gift of life. Many religious groups who are against any legalization of euthanasia take this position. What makes the interpretation of sanctity more difficult is that sanctity of life is also accepted on non-religious grounds, i.e., Edward Shils, (1968: 18-19) the sociologist, said, "Human life's sacredness is the most

primordial of experiences." Koops (1989: 39) quotes Paul Ramsey's words, "Proper stewardship can involve deciding how to live the last days of (one's) life." Trying to withhold supportive measures to prolong miserable life with consideration of both: (1) the patient to bear and (2) the family to see, Koops never takes action with the motive/intention of terminating a patient's life, but to relieve suffering, even though some treatments might shorten a patient's life. I recognize doctors have a two-edged sword: (1) machines/means to extend human life and (2) drugs to terminate life.

I believe the crucial matter is how to define the sanctity of life, while fostering a strong bias in favor of human life and then how to apply it in realistic ways. Coleman (1989: 109) states, "Killing the patient, even when done with the kindest of motives, is not the moral way to address the problem. There should be no passion of euthanasia or benemortasia." I believe all agree killing a patient is wrong as a minimum ethical standard. However, whenever that expression is put into real situations, the exception should depend on the condition, i.e., provided terminally ill patients or competent cancer patients with problematic belief systems. People opposed to euthanasia worry about the following aspects: (1) the so-called *slippery-slope,* making physicians/policy-makers have difficulty delineating the line between acceptable and *unacceptable* euthanasia, (2) verification of the patient's true wish due to their inability to communicate effectively, (3) the principle that nobody should have freedom to play GOD when facing the end of life, and (4) any efforts for alternatives, i.e., palliative care. The opposing views of euthanasia are claimed by the following organizations: (1)

Pro-Life Council with its statement of protecting the rights and sanctity of all human life, (2) International Anti-Euthanasia Task Force (IAETF), (3) World Federation of Doctors Who Respect Human Life, and (4) Citizens United Resisting Euthanasia (CURE, Ltd.).

Young (1989: 112) argues suicide always involves conflicts between the two moral principles: (1) autonomy from the Greek *autos* (self) and *nomos* (law) and (2) beneficence (our duty to benefit others embedded in the medical ethics asking physicians to act paternalistically to save life from suicide). Autonomy respected persons as self-determining agents, while their actions meet the welfare of others. Based on John Stuart Mill's idea, suicide may be the ultimate goal in autonomy by favoring beneficence in order to satisfy individuality. Suicide may be classified into the following three factors: *faith* (one's meaningfulness even when facing pain), *hope* (confidence in the future), and *love* (affirmation of self/others). I believe the interplay among the three moral issues has put us in extremely confused situations. Therefore, we have to become aware of the pitfalls among controversial ethical issues. My question is: What should we learn from pain or painful experience? Or how can we take advantage of pain in order to develop our empathy and/or sympathy, while we are going through pain? Young emphasizes the difference between respect and assent, i.e., one cannot assent to suicide, even though one may respect it, because there is no moral obligation to say, "I'll not stop you," and "I'll help you." The quality of relationships matters among the people involved. Therefore, someone may help the person wanting to commit suicide based on genuine

mutual respect, generosity, compassion, and/or altruism. I have a problem at this point, because in Japan, we do not divide these two concepts so that I find it very hard to separate respect from assent. In other words, if someone whom I respect asks me to help him or her to commit suicide, I highly regard his or her choosing suicide as autonomy and then I feel it is very hard for me to say "No, I cannot help you," to that person.

3.2 Why is death considered a bad thing?

In addition to the above mentioned three moral issues, I believe that the philosophical issue of how to measure *death* makes decisions more complicated.

Leo Tolstoy (1960: 157) shows us a classic sense of waste by the death of Ivan Ilyich, that is:

> Worse than his physical sufferings were his mental sufferings, which were his chief torture ... "What if in reality my whole life has been wrong?" ... He tried to defend it all to himself. And suddenly he realized the weakness of what he was defending. There was nothing to defend. "But if there is so," he said to himself, "and I am leaving this life with the consciousness that I have lost all that was given me and there's no putting it right – what then?

In *Murder in the Cathedral*, T.S. Eliot made Thomas say the following (1963: 68):

> Death will come only when I am worthy,
> And if I am worthy, there is no danger.
> I have therefore only to make perfect my will.

I guess Eliot seemed to have reached the conclusion that even secular people unconsciously want religious thinking, reconciliation, and purification. Therefore,

drama needs to include some flavor of religious structures to attract audience and people in general.

Unless someone comes back from death to life, I believe nobody knows whether our lives are the shadow of death or death is the shadow of our lives. Socrates was the first philosopher to question how to live well. His answer to a good life consisted of self-knowledge. Aristotle answered by appeal to the perfection of skill and talent. Catholic philosophers think of the love of God. Hume considers what one genuinely wants. Bentham believes in as much pleasure as possible. Other philosophers consider the idea of a good life negatively. What kind of lives are good ones? In western culture, dead is valued negatively, whereas life is valued positively. Christians think those who hate God and human dignity love death. In our post Christian world, meaninglessness of life and/or worthlessness of man have prevailed, because people think our life is given by accident. Thomas Nagel made the following points: The Natural view treats death as an evil due to its bringing to an end all the goods that life contains, i.e., perception, desire, activity, and thought that are constitutive of human life and/or formidable benefits in themselves, despite the fact of their conditioning of misery and happiness. The allegation is simply to treat "being alive" as "being good," even if one undergoes bad experiences. Life is worth living even when bad elements are greater than good elements, "the good ones too meager to outweigh the bad ones on their own" (1996:467). I found myself struggling with the interpretation of death. Let's go to another philosophical issue: ends. vs. means.

3.3 How should we understand the idea that *ends justify the means*?

I believe the core point of active/passive euthanasia deeply relates to the question of "Do ends justify the means?" Fletcher (1989) claims the core matter between passive/active euthanasia relates to whether the end justifies the means. If the end sought is the patient's death to offset pointless misery and dehumanization, the appropriate means is justified as *finis sanctificat media* by the old maxim of moral theologians. A physician should always construct a relationship of trust with his patients and their family, regardless of the patients' heading for death. My question is: Which means can be justified by which ends? Or Which is the benefit of patients? How should we decide what is right or wrong?

T.S. Eliot was baptized in 1927 and confirmed in the Church of England. Having learned that Christianity became the major source of T.S. Eliot's work, I could recognize in *Murder in the Cathedral* that those who serve a *cause* could make the cause serve them. For example, someone working for finance will gain benefit from the financial project. If that's the case, I think the nature of *cause* matters as the center of the evaluation and/or argument if a person really wants to behave *morally*. If someone does the right thing for the wrong reason, as in Becket's last temptation in *Murder in the Cathedral*, it shades into self-deceiving, as Eliot put it, not as *sincerity*.

Singer mentions we cannot act morally by vindicating our self-interest reasons. It seems to me Singer assumes humans by nature tend to justify our idiosyncratic causes.

There are ramifications of euthanasia, i.e., Passive euthanasia, Active euthanasia, and Voluntary passive euthanasia. Passive euthanasia means to *hasten* the end of a person by: (1) removing life support equipment (e.g. a respirator) and (2) stopping medical procedures, medications, food, and water to dehydrate or starve to death in either terminally ill patients with suffering conditions or Persistent Vegetative State with massive brain damage and/or a coma situation under which no recovery is expected. Active euthanasia is to cause the death of a person by a direct action. Assisted Suicide iincludes giving information and the vehicle for committing suicide (e.g., drugs, carbon monoxide gas) to a person wanting to end his own life without further assistance. PAS (physician assisted Active Voluntary Euthanasia) makes Jack Kevorkian notorious in the world. The most controversial form of PAS relates to patients wishing to end their lives before the onset of terminal or debilitating illnesses (Alzheimers and cancer).

Passive/active euthanasia relates to why it (with perhaps occasional exceptions) is wrong to kill a human being. It connects with "What is the difference between killing and letting someone die?" If killing is an emotional action to stop someone's life without any rationalized reasons, any killing will not be accepted under any kind of moral, ethical, medical, and legal reasons. Sherwin Nuland (1996), a physician, claims that taking one's life or assisting a person in doing so, might be permissible by considering the following two factors: (1) the unique relation of doctor/patient and (2) ethical pressures involved in an end of life. James Rachels (1996) proposes it is a distinction without a

difference. He suggests active euthanasia and passive euthanasia are *legally different*, but there is *no moral basis* to it. Then I wonder what are similarities and differences between morality and law. Having presented the following cases: (1) patient refusal of treatment and (2) the purpose of failing to treat a patient is not the termination of life, but rather the reduction of pain, Bonnie Steinbock (1996) claims the distinction between active and passive euthanasia could be supported. I know Jack Kevorkian has helped about 130 patients die. However, I wish to separate active euthanasia from passive euthanasia because there are differences of (1) intention of the originating person and (2) the process of actions taken by the medical profession. The following different arguments are raised by Rachels and Steinbock on the AMA statement (a statement adopted by the House of Delegates of the American Medical Association of December 4, 1973) below:

> The intentional termination of the life of one human being by another – mercy killing – is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.
>
> The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.

Rachels asks at first (1996: 483), "What is the cessation of treatment? If it is not the intentional termination of life of one human being by another. If it were not, there would be no point to it." Secondly, along with the notion of active/passive euthanasia, he claims active euthanasia is preferable to passive euthanasia, because the process of passive euthanasia in which a doctor does

nothing, but lets the patient die without giving medication, or being *allowed-to-die* can be relatively slow and painful, whereas active euthanasia or being given a lethal injection is relatively quick and painless. His third point is, even though people separate active euthanasia from passive euthanasia based on their consideration that killing someone is morally worse than letting someone die, what is the moral difference between active and passive euthanasia, except that one is killing, whereas the other is letting someone die? Rachels (1996: 483) mentions, "If letting die were in itself less bad than killing, this defense should have at least some weight. But it does not. Such a *defense* can only be regarded as a grotesque perversion of moral reasoning. Morally speaking, it is no defense at all." His fourth point is as follows (1996: 483):

> If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If his decision was wrong – if, for example, the patient's illness was in fact curable – the decision would be equally regrettable no matter which method was used to carry it out. And if the doctor's decision was the right one, the method used is not in itself important.

His fifth point is as follows (1996: 484):

> I have argued that killing is not in itself any worse than letting die; if my contention is right, it follows that active euthanasia is not any worse than passive euthanasia.

His sixth point is that doctors should think active euthanasia is clearly forbidden by the law with a considerable effect on their practices, or contrary to where the medical professional stands, whereas, passive euthanasia is approved. However, Rachels claims there is really no moral difference between

the two, except for some consequences in active euthanasia, as opposed to passive euthanasia which is morally preferable option.

Bonnie Steinbock claims at first that the AMA statement does not imply support of the active/passive euthanasia distinction, even though Rachels stated the AMA statement contains a moral distinction between active/passive euthanasia. Her second point is (1996: 486), "Why does Rachels think that the cessation of life-prolonging treatment is in the intentional termination of life?" Steinbock points out the following two situations in which the termination of life-prolonging treatment cannot be identified with the intentional termination of life: (1) the patient's right to refuse treatment, somehow implying a right to voluntary euthanasia or an example of the right to privacy and (2) the patient's discomfort condition to be improved. Steinbock's third point is (1996: 487), "However, the right to refuse treatment is *not* the same as nor does it entail, a right to voluntary euthanasia." The right to refuse treatment is *not* itself a right-to-die, but to protect persons from the unwanted inferences from others. I think she wants to clarify the difference between (1) the right to just stop treatment and (2) the right to go ahead, after having requested the treatment stopped, to the next level called Voluntary Passive Euthanasia (VPE). Steinbock claims that there can be a reason for terminating life-prolonging treatment other than to bring about the patient's death. The fourth point is if avoiding inflicting painful treatment on a patient is based on there being no reasonable hope of success, this is not the intentional termination of life. The permissibility of such withholding of treatment would not imply active/passive euthanasia. Steinbock is, as the fifth point,

worried if active euthanasia is regarded as morally equivalent to the withholding of life prolonging treatment.

The comparison between Rachels and Steinbock on the AMA statement would include the following two issues: (1) Interpretation of the cessation of treatment and (2) Down's syndrome children. I think Rachels does not consider the different intention and processes taken by passive euthanasia in which intentional termination of life is not expected right after cessation of treatment. Rachels, with his narrow focus, considers that the point of the cessation of treatment is the intentional termination of life, whereas, Steinbock thinks extraordinary treatment or the point of discontinuing the treatment is *not* to bring about the patient's death, but to help the patient (1) avoid treatment causing more discomfort and (2) to keep his/her right. Steinbock claims the distinction between ordinary treatment and extraordinary treatment depends on a doctor's intention, or a doctor's drawing a line between the two. In other words, I guess every doctor can set his own limitation on each patient's treatment along with the AMA statement. The crucial point seems to me what kind of treatment is to be tailored or apposite to the particular patient. The second issue relates to Down's syndrome children. Rachels regards the decision not to operate in the Down's syndrome children as the intentional termination of life. However, Steinbock urges the decision to withhold treatment is not justified by the AMA statement. Therefore, if infants are allowed to die, it is the result of doctors misunderstanding of the law and the AMA position.

Sullivan (1989), on the AMA statement of 1973, challenged Rachels by saying that AMA does prohibit against intentional killing including both direct actions and malevolent omissions. In other words, it is impermissible for doctors to terminate intentionally a patient's life, but it is permissible, depending on cases, to cease *extraordinary means* of preserving life. In response to Sullivan, Rachels argued the following two points: at first, the traditional view definitely distinguishes morally between act and intention, but what is the significance between intentional and non-intentional termination of life? If two people did the same thing, we cannot say that one acted rightly and the other wrongly, and secondly there is no clear distinction between *ordinary* and *extraordinary* means of treatment in comparison between traditional and today's medical standards.

Singer (1979) states as follows:

> I can see no advantage in survival in a comatose state, if death without recovery is certain. The lives of those who are not in a coma, and are conscious but not self-conscious, have value if they experience more pleasure than pain; but it is difficult to see the point of keeping such beings alive if their life is, on the whole, miserable (139).
>
> The existence of defective children caused great difficulty for their families, strained the available medical resources, and was often a misery for the children themselves (148).

Singer includes the following two hypothetical cases: one is a doctor who finds the plug of the respirator loose. Without his replacing it, the patient will die. After thinking of the situation, he decides not to do anything. The second situation will, with a tight-fitting plug respirator, go on working unless the doctor does something. After thinking about the case, she gives the patient a lethal injection. Which doctor will be considered as reasonable? The doctor with the

injection does wrong, while the doctor who does not replace the plug acts rightly? Singer cannot tell which is right or wrong in terms of the responsibility of doctors. In both cases, the doctors know the outcome of quick and painless death of the comatose patient and judge each result to be better than the alternative. Therefore, the doctors must take responsibility for their decisions. Doing nothing in the first case is itself a deliberate choice and no one can escape responsibility for its consequences.

In the answer to the questions "Why is killing wrong?, and letting die is not" or Should we have a moral rule against killing?, but not against allowing to die by accepting a conventional moral rule/principle of the sanctity of human life as if it were beyond questioning," Singer states as follows:

> There is no intrinsic moral difference between killing and allowing to die. ... Allowing to die – 'passive euthanasia' – is already accepted as a humane and proper course of action in certain cases. If there is no intrinsic moral difference between killing and allowing to die, active euthanasia should also be accepted as humane and proper in certain circumstances (152).

In *The New York Times* on April 10, 1999, Singer's bioethical concepts were introduced along with the quality of life, pleasure and pain, and distribution of resources. I believe it seems extremely difficult to accept no difference between killing and allow to die and/or active and passive euthanasia when family members have to choose the way to pay their last respects and/or to show their deep love to their loved one at his/her final stage. In the next chapter, I would like to focus on medical/care issues along with the latest technology-related controversial problems.

CHAPTER IV.

MEDICAL/CARE ASPECTS

The question is not "Can we commit suicide without a doctor's help?" but "How should physicians and mental-health professionals save the life of someone wanting to kill himself, by asking what kind of questions?" Then, in the case of choosing death, How to medically define death comes as the next step by applying contemporary medical professionals' points of view along with cutting edge technology-centered reality of terminal heath care. In the midst of the struggle between life and death, how can patients, especially terminally ill patients, empower themselves for the best possible treatment with the backup of their family members who could give constructive feedback to doctors to change at the last minute to much better treatment? What would be the ideal relationship between doctors and the patient's family members? I recommend, without hesitation, a horizontal and co-helping situation between doctors and a patient/his family members for the sake of the patient.

4.1 How should physicians ask before assisting suicide?

Battin (1994: 271-276) (originally from *Crisis* 12:2 (1991): 73-80, entitled "Rational Suicide: How Can We Respond to a Request for Help?") states the following 17 points under "Assisting in Suicide: Seventeen Questions Physicians and Mental-Health Professionals Should Ask.": (1) Is the person making a request for help? (2) Why is the person consulting a physician or a mental-health professional? (3) What has kept the person from attempting or committing

suicide so far? (4) Is the request for help in suicide a request for someone else to decide? (5) How stable is the request? (6) Is the request consistent with the person's basic values? (7) How far in the future would the suicide take place? (8) Are the medical facts cited in the request accurate? (9) How accurate are other nonmedical facts cited in the request? (10) Is the suicide plan financially motivated? (11) Has the person considered the effects of his or her suicide on other persons? (12) Does the person fear becoming a burden? (13) What cultural influences are shaping the person's choice? (14) Are the person's affairs in order? (15) Has the person picked a method of committing suicide? (16) Would the person be willing to tell others about his or her suicide plan? And (17) Does the person see suicide as the only way out? Even though the above questions are all essential, I could add as a person carrying Japanese cultural baggage that the person's family members and/or friends should also be investigated to see how much others' views have led to the person's psychological mal-function and/or unexpected development. Because in the Japanese cultural climate, suicide is *not* limited to a person's bad attitude, but it is also considered as the worst scenario pulling down the reputation of the entire family and all relatives of the person attempting suicide, particularly when a third party tries to evaluate that family/relatives just before making any decisions, i.e., an engagement, a marriage, and/or employment-related arrangements.

It seems to me that any suicidal attempt relates to the quality of life that Volicer states (1994: 597-603 and 1997:196-197): "Meaningful activities, medical issues, and psychiatric symptoms are the three ingredients of the quality of life.

Therefore, the area in which all the three are overlapped is genuinely called *niche* of the quality of life." Dr. Volicer works for Alzheimer's disease patients, but his comments appear beneficial all human beings, regardless of the seriousness of our health conditions, because, I believe, we are psychologically vulnerable or fragile creatures who could easily be influenced by our mood and/or feeling, especially, depending on any negative input from our surrounding people and/or situations. Therefore, I think the core or major element of care should be based on the following questions: "How should I approach someone wanting to kill himself/herself? Or What is the goal of that person? Or What is the goal of care? Or How can I, a person with limited capacity, help him/her?"

4.2 What causes Death and How should it be defined?

Regarding when someone is considered as *dead*, Nagel's answer seems ambiguous. Nagel (1996: 469) stated, "So long as a person exists, he has not yet died, and once he has died, he no longer exists; so there seems to be no time when death, if it is a misfortune, can be ascribed to its unfortunate subject."

According to *Definition of Death* (1968) by Ad Hoc Committee of the Harvard Medical School, irreversible coma or, no discernible central nervous system activity, is defined as a new criterion for death. In other words, a growing consensus is brain death by rejecting the traditional heart-lung death criteria. The characteristics of irreversible coma include: (1) unreceptivity and unresponsitivity, (2) no movements or breathing, (3) no reflexes, and (4) flat electroencephalogram. The important points are: all of these tests shall be

repeated at least 24 hours later with no change. Because to accept someone's death is the most unacceptable in our life. More than medical problems, moral, ethical, religious, and legal issues should also be highly regarded in case of investigating one's death and eventually reaching the final decision.

The Uniform Determination of Death Act (UDDA) proposed in 1981 stated below:

> An individual who has sustained either 1) irreversible cessation of Circulatory and respiratory functions, or 2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. The medical profession, based on carefully conducted research and extensive clinical experience, has found that death can be determined reliably by either cardiopulmonary or neurological criteria.

In reference to the above statement, Orlowski, director of pediatric intensive care at the Cleveland Clinic Foundation, a hospital and educational institution, claims (1990) that mechanical ventilators and medical interventions could keep circulation and respiration despite a loss of all brain functions. Therefore, Orlowski considers a patient dead whose loss of brain function was complete and irreversible. In other words, brain death is true personal death (the death of a person) medically, legally, and philosophically. As the brain is the most sensitive organ to lack of blood flow or oxygen, the following two ways cause to die without serious damage to other organs: (1) severe head trauma with direct and total destruction of the brain and (2) a cerebral insult leading to a vicious cycle of cerebral edema and reduced cerebral perfusion exacerbating each other until blood flow ceases. The three criteria of brain death for a clinical determination are: (1) coma of established irreversible cause or exclusion of reversible causes of coma, (2) absence of cerebral function, and (3) absence of brainstem function.

Evers and Byrne (1990) argue that traditional heart-lung criteria for death should be used because medical technology is not advanced enough to enable physicians to pronounce a person dead, while the heart and lungs are still functioning. Shapiro (1990) points out that persons in a Persistent (or Permanent) Vegetative State (PVS) with unconsciousness due to the upper portion of the brain having failed, though enabling bodily functions to continue, should have their medical treatment and artificial feeding stopped according to this expanded notion of death. The reasons are: (1) a person in a PVS cannot experience pain or discomfort from life-sustaining treatment so that the patient's best interest is to withhold such treatment and (2) PVS lacks consciousness of whether he lives or dies, or either does not matter. Shapiro claims (1990) clinical uncertainties presently prevent accepting the redefinition of death: whether or not to include a permanent vegetative state. Grimstad (1991) claims even PVS or unconscious patients are not dead so that to withhold treatment and artificial feeding is immoral. All we should consider is to secure compassionate treatment for the dying. Veatch (1989) proposes death should be determined by individual choice, because the question of a person's being considered dead, while the body still functions but consciousness is permanently lost, is a philosophical question which cannot be solved only by scientific criteria or legal statues. The point to further discuss is that a society has a basic interest in defining for all people a *set* basis on the following two factors: (1) who is alive with protections/benefits of law and (2) who is dead. How can we possibly create the above mentioned basis depending on different kinds of moral values/ethics?

Humber (1991) accepts a dilemma in which if states accept either the brain-death or neocortical-death, they run the risk of declaring human death, whereas, if states accept the heart-lung criteria and use these criteria to protect human life, they do not know all beings protected are living human beings. To avoid the dilemma, Humber suggests to adopt the heart-lung criteria as human death or a mere *offer* of protection for individuals to be free whether to accept that offer or not. Prior to jumping into that conclusion, I think we need to scrutinize what "living-human being" really means. We should create any practical standards for the 21st century based on the following investigation/research: (1) various difficult cases in our real world to make us put in troubles due to lack of moral, medical, legal, and other reasons and (2) controversial issues on how to apply the latest technology to make a person alive.

4.3 What would be the best treatment for terminally ill patients?

Anderson (1991) recommends hospices for their two primary principles: (1) the terminally ill person's own preference and life-style are the major factors in all decisions about care and (2) the legitimate needs and interests of family members/caregivers deserve consideration. Brower (1992), on the other hand, suggests hospices may not be the best place based on her mother's experience in which she was asked to forgo any curative treatment. Duda (1987) believes home is the best place to regain personal power surrounded by familiar faces, since the right to refuse treatment has become popular. Ajemian and Mount (1985) indicate hospitals are the best because of providing specialized care. Some hospitals have a hospice unit attached for palliative care as well as

conventional acute care wards. Quill (1994) states physicians should assist in euthanasia, because a doctor's job is to help relieve suffering, while improving the doctor-patient relationship. Moroney (1992) claims physicians should not assist in euthanasia, because once they put patients in the *dying category*, they ignore their feelings and only cause shortening of life, while prescribing useless pain treatment.

Having read the above comments, I wonder what strategy I should take to fully understand their differences and/or similarities. All I need is at first to distinguish between fact and opinion, secondly, to separate statements of fact from statement of opinion, thirdly, to analyze the differences between those statements, and fourthly, to find out any statement impossible to judge.

4.4 Who should make decisions about euthanasia?

This question may be paraphrased in other way, like "How could patients control their final treatment?" Taylor (1994) states individuals have the right to decide for themselves, like Jackie Kennedy Onassis who left the hospital to stop her treatment for cancer. Kelly (1992) claims the family has the right to decide for loved ones, because the family should work as a surrogate decision maker. McCord (1993) argues public policy can guide decisions, because everyone cannot escape or it is everybody's business. Callahan (1992) mentions no one has the right to make decisions in support of euthanasia, because euthanasia-related debate represents turning points of the following three aspects in western thought in our pluralistic society: (1) the legitimate conditions for a person to kill

another in voluntary active euthanasia, (2) the meaning and limits of self-determination, or the acceptance of euthanasia would sanction a view of autonomy, and (3) medicine has become a business to promote individual pursuit of well-being. Brody (1989) thinks living wills are the best way to enable patients to control their own end of life, whereas, Thomas (1992) suggests living wills have no effects on a patient's right to die. Voulo (1991) indicates living wills can lead to unnecessary deaths because of dangerous language and its interpretation. Kjellstrand (1992) mentions physicians are reluctant to discuss their patients' death and the option of limiting artificial life support measures so that doctors can use Advance Directives (patients' specifying in writing what kind of treatment they want in the event of terminal illness) to help dying patients, whereas, Alper (1992) claims physicians question the benefits of Advance Directives so that they do not need Advance Directives.

The next question is to compare the following two situations: vertical (doctor-centered) vs. horizontal (patient's right-not-forgotten, or the patient and the doctor's co-helping situation). Rachels values the doctor's decision so that the method (active/passive euthanasia) used is not important. Steinbock separates the cessation of treatment from the intentional termination of life. In other words, Steinbock accepts some stages within the whole process between the doctor and the patient's relationship, i.e., the patient's right and making the patient comfortable. Sullivan values *intention* of doctors who prioritized to reduce pain, not to kill patients. Singer claims no difference between active/passive euthanasia. I strongly believe mutual trust between doctors and a patient/his

family members is what matters most in case of discussing many kinds of concerns in a limited time. The biggest concern among family members is how to rationalize or reduce their feelings of guilt when they ask doctors to perform passive euthanasia for their loved ones.

I think the AMA statement is full of ambiguity, i.e., What does intentional termination mean? How does mercy killing relate to intentional termination? What does irrefutable mean?; and What kind of advice and judgment of a physician should be available to a patient and his immediate family? I believe there are basically the following three areas: (1) a doctor's function, (2) a patient's role, and (3) doctor/patient mutually shared areas. Doctors should take responsibility for medical treatment from inception to the end, while constantly discussing with a patient and his family members how to treat the patient. I wonder "Who, when and how to decide cession of treatment?" Who?: Both of the doctors and the patient and his/her family members. When?: At the time when no further treatment would improve the patient's condition. I think doctors should be honest to talk about their difficult treatment and/or inability in cases when no further improvement of patients is expected, even with the latest medical knowledge. I wonder "What requests can a patient and his family members make of doctors?" The reason is that family members as well as patients should educate themselves on the latest medical research/information through reading/the media in order to catch up with doctors' knowledge on treatment and medical technology.

CHAPTER V.

LEGAL ASPECTS

When and how can we use our rights as an individual and/or a person in a society where certain norms are kept for social justice? At what stage should law intervene in order to change the flow of general public's opinion? Legal aspects relating to the power of each group with various ways of thinking embedded create serious problems among parties who primarily want to strengthen their own interests only. To set up law is a step for the beginning. However, the matter we genuinely need to ponder is: *Who* would benefit from *What* kind of law? As long as people want to enjoy any creative and/or limitless implementation processes, law itself is always subject to change without any hedge. Let's think about the legalization of euthanasia.

5.1 Should euthanasia be legalized?

I think the autonomy of patients, patients' best interest, and value of human life itself interplay in terms of the legalization of euthanasia. Having accepted the above mentioned tendency, conscientious people worry that old and vulnerable patients might be forced to ask to die. However, other serious arguments would be: What happens if someone who truly wants to die is forced to live. Therefore, legalizing no euthanasia is harmful to this kind of person. Whether in legalizing or refusing to legalize, we have to know dangers on both sides. Therefore, the rival dangers must be balanced out, or neither should be ignored by doing our best to draw and/or maintain a defensible line as the guard

against the risk of drawing the line differently in the future. In Nancy Cruzan's case, she lost control of her car one day in January 1983 in Missouri. She lay in a persistent vegetative state even though she had told her housemate that if sick or insured, she would not wish to continue her life unless she could live at least halfway normally. This was the first time the U.S. Supreme Court had been faced with what we call *the right to die.* They said that Missouri had *arrogated to itself* the power to define life, and Nancy Cruzan's life and liberty consequently were put into disquieting conflict. She had not made a living will, and the court case paved the way for the uniform, national Patient Self-Determination Act, that regulated living wills and made them more widely available. The hidden assumption is: What is in the best interests of a patient? How does autonomy relate to the best interest of patients in a permanent vegetative state? If we accept the possibility of some chance of a miraculous recovery, we can no longer rely on medical statistics of recovery as an excuse for not doing what the patient might have wanted.

Dworkin mentions the question raised by euthanasia is how life's sanctity should be comprehended and respected, not whether the sanctity of life should yield to other values, i.e., humanity or compassion. Euthanasia involves decisions not about the rights and interests of some people, but about the intrinsic, cosmic importance of human life itself. The values in question are at the core of everyone's lives and no one can offset them so as to accept other people's orders about what they mean. Dworkin (1993: 217) points out a devastating and odious form of tyranny in which someone is forced to die in

accordance of others' approval, when he/she believes it is a horrifying contradiction of his/her life.

5.2 Yes and/or No on Legalizing euthanasia

Followings are a summary of various kinds of ideas: Dougherty (1993) claims legalizing would devalue all life in society, because suffering is a part of the dying process which would be reduced by hospice care, family involvement, and spiritual counseling. Pridonoff (1994) points out that appropriate safeguards could give patients the power to end their suffering. Lessenberry (1994) argues Physician-Assisted Suicide is a Constitutional Right, because a rational person has the right to refuse medical treatment as a matter of choice. Passive euthanasia was accepted for comatose or brain-dead patients, such as, Nancy Cruzan and Karen Ann Quinlan. Leo (1994) states Physician-Assisted Suicide is not a Constitutional Right, because this is expected to increase suicide. Having read all the above ideas, I feel it is extremely hard to judge and/or choose any one of them, because the individual specialist evaluates the legalization of euthanasia based on their own position only. Each idea has been biased/skewed in a certain way. How can I possibly avoid the situation said in a proverb, "We cannot see the forest for the tree."

5.3 Kevorkian

How about Jack Kevorkian who goes around and kills innocent people? The latest news came out on Friday, March 26, 1999 in which Jack Kevorkian was

convicted of 2nd degree murder due to the 60 minutes video of his assisted suicide aired late last year. Even the AMA stated that Kevorkian prematurely terminated lives of patients. I would like to ask that WHO (the World Health Organization) create worldwide safeguards to set a minimum standard of euthanasia for humane reasons, with further details to be left to each country's option.

CHAPTER VI.

TEACHING MATERIALS ON EUTHANASIA

How to present euthanasia, a burning issue in the world, to Japanese college students has been occupying my mind. Sometimes I think of my teaching materials as a kind of food to help nourish my students in the near future. What kind of ingredients, that is, layout of a textbook, would attract them to eat? The remaining part of this chapter explains about ten lesson plans, i.e., teaching climate in Tokyo, goals for reading comprehension, students' objectives, language used in the classroom, and teacher's role as a facilitator. Particularly, a role-play is expected for the purpose of: (1) exchanging views on euthanasia, (2) sharing empathy, and (3) building trust among participants. A *three-minute*-presentation at the final class and reflective journal writing right after each role-play also contribute to the evaluation of the students.

6.1 Ten lesson plans: These focus on (1) English reading comprehension and (2) a role-play with at least three people discussing how to cope with euthanasia-related situations. All the reading materials are published mainly in the U.S. and relate to the ethics of euthanasia, i.e., philosophically controversial ideas between God and humans in ancient and medieval times, contemporary family problems, doctor-patient relations, hospital/hospice, pain management, legal issues, and the Netherlands-based application of euthanasia.

6.2 Teaching Situations:

teaching places: Colleges in Tokyo, Japan.

Students: All Japanese college students aged around 18 - 30 years. They all at least have finished six years learning English in junior/senior high schools.

General cultural climate: Generally speaking, people including college students even in Tokyo are rarely interested in talking about euthanasia. English is taught as a foreign language primarily emphasizing reading and writing, not speaking and listening as a means of communication. Therefore, nobody expects to communicate in English in any daily interaction. Euthanasia-related recent tendency in the U.S. is not the other side of the Pacific Ocean. The same wave has been sneaking into Japanese soil. Those who are interested in euthanasia-related latest worldwide movement have been increasing, even though Japanese mainstream media has ignored the new wave, by simply agreeing with the ordinary people who only want to stay away from any negative, particularly, death-related issues.

6.3 Goals: The primary purpose is to let Japanese college students be exposed to the latest news of euthanasia through reading reliable newspapers and periodicals in English. Since the process of reading comprehension is from identifying the written symbols to intertwining the content with readers' schema/background knowledge, reading materials would pave the way to a role-play. The secondary goal is to introduce Critical and Creative Thinking (CCT) to

the students. The third goal is to participate in a role-play which will function as the vehicle of sharing different ideas and empathy, personalizing all humans' basic and deadly serious matters, and building mutual trust among participants. Once they finish the course, it is expected: (1) their listening and speaking skills will be increased because of the interaction of a role-play in order to get their message across, just like a problem solving and/or decision making process and (2) their attitude will be shifted to feel okay to exchange their own opinions of euthanasia in their daily life. The ultimate goal is to make the students ponder about what would be the better solution of *good death* for themselves, loved ones and relatives.

6.4 Students' Objectives: Japanese students lack knowledge of both (1) the latest information on euthanasia written in English and (2) so-called western ways of thinking and conveying an individual's message across within a group, such as, in a role-play. Having accepted this reality, students at first are expected to comprehend prepared English reading materials. Secondly, to ponder the content of the materials in terms of both CCT and comparative cultural analysis between Japan and the U.S. Thirdly, to participate in a role-play to wind up each lesson so as to show how much an individual student can demonstrate his/her level of intertwining the core of reading materials with the role of each role-play along with his/her own personal experiences/schema together with empathy and impartiality.

6.5 Language used in a classroom setting: Since this course is called *Content-based English learning: contemporary issues in the 1990's*, English is used in all interaction between teacher/student and student/student in the class, except for questions asking for any translated Japanese words.

6.6 Teacher's role: As CCT has not been launched in Japanese soil, even in central Tokyo, a teacher has to input what CCT means and how to apply CCT, while reading English materials. A teacher needs to create Socraticly-oriented questions to scaffold students' deeper understanding of the content of the reading materials.

Schraw and Bruning (1996:295) create a questionnaire making students pay attention to the following points of reading: (1) How have you enjoyed sharing the thoughts and reactions of characters in a book? (2) Have you ever imagined to live through the experience while reading. And (3) Have you focused more on how you feel about the information than on what you learn? The above points help students eventually *personalize* the content of the reading materials.

By clarifying with the students how reading materials are used to identify, reconstruct, and evaluate problems, a teacher can lead them to any argument analysis on their own at first to create their foundation of discussion. A didactic stage, such as to give lectures, is not included in my lesson, because it is anticipated, by the time each lesson's discussion in a whole class approaches the end, that the students would holistically have the opportunity to exercise and sharpen their new analytic skills. A teacher is to emphasize the following six

aspects: (1) to obtain what writers advocate, (2) to analyze and to sense a subtle nuance, (3) to recognize indirect references, (4) to detect assumptions embedded, (5) to guess unstated conclusions, and (6) to seek false reasons or ambiguous premises to formulate rational judgment about whether an argument is genuinely persuasive, even if the student does not ultimately agree with authors' positions.

6.7 Role-play to develop participants' discussion, empathy, and trust:

Japanese students have rarely experienced a role-play in their education. A teacher needs to introduce: (1) the merits of a role-play as a vehicle to raise awareness of any problems; (2) the process, and (3) how it is done at the end. By observing students' participating process, a teacher or, a facilitator, needs to scaffold students' understanding, particularly to help develop their inner abilities, and most importantly to provide specific feedback at debriefing sessions immediately after a role-play. If a teacher can help the students go beyond Japanese cultural norms and challenge them to welcome foreign ethical, legal and religious approaches, the teacher seems to have successfully functioned in Japanese classroom settings. The biggest conundrum I myself experienced in a role-play was: How can I take risks in the following aspects? At first, subject-wise: when and how to tell my own idea. Secondly, language-wise: how non-native speakers of English could come across the connotation and denotation of English words shared among native speakers of English. These double hurdles make me totally feel *dumb* in the midst of a role-play. In order to positively participate in the process of a role-play, let me explain about Newberry's three

ideas of how to conduct a role-play (1996): at first, to encourage students to consider doing a role-play as a performing art, secondly, to characterize the classroom to determine whether it's conducive to learning, and thirdly, to stir the objective of the class. Nolan (1996) based on research suggests that students learn differently depending on the following tasks: 10% of what they read, 20% of what heard, 30% of what seen/heard, 70% of what they discussed with others, 80% of what experienced personally, and 95% of what they teach to someone else. I must unfortunately admit there is no cooperative teaching/learning among students in Japanese classrooms, because they all compete with one another without voluntarily wanting to help their peers out. In order to break this conventional behavior among Japanese students, a teacher should urge them to benefit from helping their peers, by the teacher's saying, "Teaching some problems to your friends is good for you too, because you can gain experience in problem solving processes and also confirm your understanding with your friends." Students, right after a role-play, are supposed to reflectively look at their own utterances/body language taken during the role-play in terms of: (1) How could I differentiate fact from assumption? (2) What kind of thinking did I have just before a role-play? (3) What sort of processes did I take as the person of my role? For example, was there any negotiation recognized with other members? (4) What sorts of *assumptions* most influenced my interaction? (5) How did I evaluate my group's emerging thought, priority among contradictory issues, and/or any consensus? (6) What lessons did I learn today for future reference? And (7) What cultural differences of moral/ethics did I perceive

between my role and Japanese morality? As Goleman (1995) claims, *knowing thyself* consists of the following three factors: (1) becoming aware of feelings, (2) coming up with thoughts, and (3) acting to change actions, because thoughts and actions usually go together. As a Japanese teacher, I observed priority differences between Japan and the U.S., such as, we tend to control students in Japanese hierarchical culture, whereas, American teachers come down to students' level to understand their feelings/problems and then to help them out.

On moral concerns and social skills, Kohn (1990) mentions that students need to develop the skills of moral concern to bring win-win negotiation, regardless of various values, to balance between self-centered ideas and other-related matters. It seems American parents have limited time to build relationships with their children just like their Japanese counterparts. I could imagine my students will struggle with a role-play in hypothetical situations of euthanasia and talk to themselves as follows: "I have never done a role-play. How difficult to act out in a role-play! As long as my daily life goes on without any big problems, I do not need to think about any bad situations! No thanks! If I imagine a bad thing, I get afraid that bad thing might sneak into my real life in the near future. I've never heard of euthanasia. I've never thought about end of life matters even in my first language, Japanese, because my parents are healthy, though grandparents had gone before I was born. Should I demonstrate a role-play as a part of English lessons? Why should we communicate in a foreign language, English, while I am right now physically in Tokyo? Give me a break!"

As a vehicle of executing a successful medical ethics-related discussion, Kodish (1998) suggests to apply the distinction between (1) statements of fact and (2) statement of inference. For example, "I prefer X, " or "I find Y bad," can limit the responsibility of utterance within the speaker, by turning an uncritical inference into a statement of fact. Uncovering our own values helps others uncover and clarify theirs. Recognizing the distinction between fact and inference statements allows us to see how we can reach judgment or inference comparing with a given fact. To separate statement of fact from statement of inference reminds me of Hume's anecdote: "These apples are bitter" doesn't automatically lead to "You shouldn't eat any of these apples!" I value the following idea of Kodish (1998: 135): "If ethics involves making decisions among competing values, circumstances, consequences, etc., then ethical considerations of some sort, either trivial or serious, permeate every aspect of living." I believe no one can stand alone in a society. Or hypothetically, nobody can just enjoy one-man-luxury in his own island of the Pacific Ocean for his/her entire life. Therefore, what I want to get the message across is if ethics influences decision making in the middle of total chaos, every facet of our living should be under our ethical scrutiny prior to any decision being finalized. And that underlined notion should be recognized by all participants of every role-play in the lessons. I believe that the more seriously we act in a role-play, the more we can get out of that experience.

I strongly believe the hardest thing is to do the following two things at the same time, while working for a role-play: (1) to show your empathy to other

members and (2) to ponder fairness and impartiality along with Critical and Creative Thinking for better process and outcome. Every second in a role-play is a thrilling learning experience in how to adjust myself or how to switch gears by others' input. I believe a role-play is like a living creature. It is like a baby who all of a sudden begins to cry if I am mean to that cute creature by hiding how much I deeply love the baby. One thing in common between role-playing and a little one is *fragile* nature. Unless we always watch them carefully, a chaotic situation to erase a happy moment might come up at the next second, by any participant's unexpected or out-of-the-blue utterances. I hope my students could take advantage of a role-play for looking reflectively at themselves about their own speaking, listening going beyond the words in order to comprehend the hidden ideas, interaction manner, assumption, interests, fair reasons, perspective, and most importantly, building trust among members. Based on my trial and errors in the U.K., Australia, Canada, and the U.S., I would say, regardless of topics, any human's interaction between a small talk in our daily life and negotiation and/or mediation process would make us struggle with our anxiety vs. ambiguity in communication.

Listener's Perception: Carl Rogers (1961:44) describes the emotional quality of the relationship between a psychotherapist and a client as follows:

> One is the fact that it is the attitudes and feelings of the therapist, rather than his theoretical orientation, which is important. His procedures and techniques are less important than his attitudes. It is also worth noting that it is the way in which his attitudes and procedures are *perceived* which makes a difference to the client, and that it is this *perception* which is crucial.

I understand a positive attitude of a client is derived from a therapist's genuine desire to develop empathy for the client. Honeyman (1990: 23-36) claims that persuasion and presentation skills include "maintain[ing] eye contact and positive gesture [and] competently us[ing] all tools of communication." In Japanese culture we never try to gaze at the interlocutor's eyes at the most important point of our conversation and/or discussion. Therefore my students are expected to become aware of the cultural difference and try to experience the necessity of eye-contact as body language, while acting out a role-play.

Hearer's Intentions: an utterer's intention and/or meaning is consciously and/or unconsciously transformed by a hearer based on his/her schema and background knowledge. Or a hearer should be careful or humble enough to recognize that s/he cannot escape from his/her own experience-based skewed ways of interpreting an utterer's meaning/intention. Grice (1969: 147-177) suggests that a hearer' role is so crucial, because a hearer may understand or misunderstand. A good listener is *not a passive person* to construe an utterer's intentions, but attends the utterer's unique ways of conveying a message.

Hearer's subjective thinking: Grice (1969) claims that no meaning explosion exists, due to the meaning arising from the connections sustained by individuals. It seems to me that Grice tries to make us recognize the limits/ceiling of each person's listening ability which will never go beyond his/her experience or just stays within the individual's experiences, or which would never become identified as the same level as the utterer's content and context. In other words, there is always a gap between an utterer and a hearer. Therefore, what any hearers can

do is to try out in their mind their understanding juxtaposed with the utterer's content. I think the gap in understanding the content of a message between a hearer and an utterer is analogous the difference of understanding the content of a book between reading a book in the original language and in a translated language, because they never reach the same level, but only narrow down the gap between the two. Pellowe (1986:13) claims, just like Grice, that meanings are related to an individual's sense of connection, and are not outside of hearers, and can not be objectified. If I ask a question to **X**, "What is the meaning of **Y**'s remark?" The meaning is connected between me and **X**, not between me and **Y**. The hearer tends to create his/her own meanings to answer the question. Even though listening to the interlocutor's utterances, we, very subjectively, tend to unconsciously frame the utterer's words through *our own filters* and then, to create or compile our own favorite draft or scenario based on the following factors: (1) our background knowledge, (2) our experiences, (3) our interest, (4) our beliefs, (5) not taking the *face value* of the utterances, but paraphrasing constantly the interlocutor's words and/or expressions to make us easily understandable, just as we take a *short cut* on the interlocutor's intention without worrying about what consequences will happen due to misunderstanding, (6) inquiring in our mind, "What makes him think like that?" (7) carelessly making errors, while listening, (8) not understanding the inferred meanings due to a lack of linguistic knowledge, (9) stereo-typical ways of comprehension without any understanding of *unspoken cultural aspects*, and (10) a lack of catching and then following the flow of interaction in the specific context. Nichols (1995: 62-140), a

Professor Psychology at the College of William and Mary, mentions, "More than we like to realize, we continue to live in the shadow of the families we grew up in. Our parents may be the most important unfinished business of our lives." I think any surrounding conditions in our developmental stages are likely to influence us one way or another.

Reframing: The fact everybody has different views based on his/her frame and lens can work either as a stumbling block to mutual understanding, or powerful leverage for positively influencing how others see the same role-play from other side. In reality, we, unfortunately or fortunately, could never throw away our own frame and lens. I should listen to the interlocutor's explanation with his/her frame and lens, while I am aware of my own frame and lens. I think the question is what frame is expected to make a role-play a neutral process. Watzlawick (1978: 119) states:

> We never deal with reality per se, but rather with images of reality --- that is, with interpretations. While the number of potentially possible interpretations is very large, our world image usually permits us to see only one --- and this *one* therefore appears to be the only possible, reasonable, and permitted view.

I think Watzlawick's *image of reality* means *reframing* by individuals.

Active listening: Effective listening is a crucial skill, even though extremely difficult to really listen well as Moore states as follows (1986: 192):

> Particularly helpful skills are active listening, restatement, paraphrase, summarization, generalization, fractionation, and reframing.

The more I deeply scrutinize the interlocutor's meaning, intention, subtle differences, and nuances including the hidden or unspoken parts, the more I feel how little I have grasped the utterer's content, and then I ask myself, " Why should I turn to that way?" Or "Would I stop for a second before making my judgment?" Or "Put myself into the interlocutor's shoes to evaluate the same problem from the other side." Or "Be humble yourself to learn anything from the interlocutors' utterances/behaviors!" Raiffa (1982: 337) wisely points out as follows:

> My concern has been to indicate how some modest analytical ideas can help negotiators and intervenors. But in most conflicts, the main part of the problem --- and a necessary preliminary to analysis --- consists in getting people to talk and listen to one another.

Empathy and Dilemma: I wish that a role-play could motivate students to develop their empathy to others' problems and then to build trust among participants. On empathy, More (1994: 92) working on the relationship between empathy and cognitive problem-solving skills states as follows:

> Empathy at its best preserves yet seeks to know the strangeness, respects the boundaries between self and other that the 'forbiddenness' affirms, does not seek to assimilate or obliterate the freedom.

On evaluating Mediators, Honeyman (1990: 23-36) includes *empathy* representing conspicuous awareness and consideration of the needs of others together with the explanation below:

> Avoided appearance of bias or favoritism for or against either party. Asked tough questions of parties, but did so in a sympathetic manner. Demonstrated concern for parties' feelings. Effectively fostered working relationship with parties through actions and attitudes. Listened politely to others and responded with understanding.

With a suggestion of not to confuse empathy with sympathy (meaning to share the same feeling), Nichols (1995: 62-140) indicates as follows:

> Listening is the art by which we use empathy to reach across the space between us. Passive attention doesn't work. Or "Genuine listening means suspending memory, desire, and judgment --- and, for a few moments at least, existing for the other person. Or, an empathic response is restrained, largely silent; following, not leading, it encourages the speaker to go deeper into his or her experience. Do you rely on sympathy and presume you understand, or do you use empathy and work at it?

We have a saying in Japan, "Others' words/behaviors work as a mirror of reflectively looking at yourself," meaning to take advantage of observing others to reflectively evaluate yourself on how much you should adjust against any appropriate norms.

Feedback and self-disclosure: The following *Johari Window* is helpful for everyone to raise awareness about pitfalls hidden in an interaction:

	I Know About You	I Don't Know About You
You Know About Yourself	(1) Your Open Self	(2) Your *Hidden/Secret* Self
You Don't Know About Yourself	(3) Your *Blind* Self	(4) Your Undiscovered or Subconscious Self

Having recognized the above hidden reality, we should be sensitive to how language would create good/bad circumstances in between: (1) to cause a conflict or to psychologically kill someone by eliciting feelings of threat or defensiveness and (2) to encourage someone to live. What will happen if we share our knowledge, attitudes, and behavior without feeling of threat of

defensiveness? I believe we will find a great potential for a problem-solving process/outcome together with mutual trust building as a *by-product.*

Based on my experience, **trust** among participants of a role-play will be constructed with the following focuses: (1) To get to know one another to help surface and make conscious about the shared underlying assumptions and belief systems to tie us together into larger systems; (2) The more we practice in a group as a new way of *being in relationship*, the more easily we can shift our thinking patterns to support a role-play, i.e., collaboration, the qualities of cooperation, working together, how to handle conflict, and how to make decisions to solve problems; (3) Having learned from one another's authenticity, we can develop a sense of shared meaning which will make us go beyond cultural stereotypes, i.e., to learn to think together by conversing deeply on a topic helps us experience in a shared meaning to bring the basis for some coherent actions; (4) As frequency of a role-play keeps on, participants tend to become more open to reveal their own thinking process and ask others to provide their applicable suggestions to break through *wreckage* or *impasse* of interaction, while they try to suspend judgment; (5) To talk about conflicting assumptions which are uncomfortable, even though they are acceptable in the foundation of a role-play, tends to pave the way to create greater trust, i.e., to surface and to work with assumptions prior to jumping into decisions; (6) The process of a role-play helps bring real-timed awareness of relationship among participants. The time shared/struggled together is accumulated like a *saving* to develop mutual trust later on; (7) To learn an individual's freedom as coupled with shared

responsibility is a key to creating a sense of a group-consciousness, i.e., when we exchange honest views, we can create a culture of sharing and respecting different values, or only when we begin to listen to collective meaning for the inter-relationships among the events, we will be able to expand our understanding to create new possibilities; (8) We can recognize *collective intelligence* appearing to accept a notion in that two-heads are better than one, because a better outcome is expected than only one. Accordingly, we need to take advantage of collective collaboration by learning/stimulating one another's perceptions and/or behaviors on how the world might be working; (9) Silence (not *impasse* in negotiation and mediation, but all concentrating time on the specific issue in a role-play) should function as the *prelude* to a precious and constructive exchange of different views in which dynamics of processes, through all participants' taking their roles, would emerge just like any *real impromptu talk* which will give an impact on listeners; (10) The process of clarifying different thoughts or diversity based on genuine curiosity and inquiry contributes to mutual understanding with deeper shared meaning and eventually to create our trust; and (11) any brand new solution should be derived from the merits of all participants' integrated diversity.

A debriefing session is scheduled at the end of each lesson by letting the reporter of each group come up to the front and summarize their outcome to a whole class. Then a teacher should throw the following questions to help students go beyond to wider perspectives: "If the results reported right now had

been real life, what are some things that could have happened next?" Or "What do you think they should do to solve their problems?"

6.8 Three-minute Presentation and journal writing: In the last class, every student is expected to talk on "What is my version of end of life?" within three minutes. For the checklist of the presentation, please refer to Appendix 1. Reflective journal writing right after each role-play is anticipated with the maximum length of *one page* only.

6.9 Evaluation: Participation in discussion to solve the questions is (20%), role-playing (30%), journal writing (30%) as the reflection of each role-play, and a three-minute presentation (20%) at the last class. The percentages in parenthesis show their level of importance for the evaluation.

CHAPTER VII

IMPLICATIONS FOR THE FUTURE

Relativism opened up the discussion of valuing different ways of thinking. The expression, diversity, has become popular, asking us to consider peacefully living together as neighbors, regardless of different value systems, background, schema and/or experiences. The ever changing notion/concept of the word, euthanasia, is an example of how diversity in 1999 has been working in the real world in which people tend to interpret euthanasia in numerous different ways to rationalize/satisfy their own idiosyncratic value systems. As long as humans live in this world with an arrogant attitude toward the God-governed universe/Mother Nature with the help of cutting edge technology, euthanasia will remain as a burning issue with room for humans' limitless interpretations.

Having said that, ethics has not given us an insight into how to live and make decisions in our real world. Ethics seems to drag behind and/or has not yet caught up with our real-world-based fast changing social phenomena. Ethics has become under an individual's and/or people's control. Ethics itself is likely to become *situational ethics* in which no ultimate ethics exists or all depends on a case by case analysis. Under such circumstances, I think everyone has to apply *self-discipline* to his/her daily life which is based on one's own version of ethics. I wish to exchange views on euthanasia with an interlocutor by creating critical questions, i.e., what do you mean by that?; what does it mean?; why do you think so?; how do you know that is true?; where do you get information?; what is behind it?; what happens if you are wrong?; and/or what happens if it is

wrong? In other words, only people who face euthanasia-based reality can start puzzling about what would be the hidden crux for a solution and how multi-layered ethics would be dealt with. As the concept of euthanasia has been mushrooming together with numerous interpretations and applications, I wonder how ethics should survive with the cooperation of and/or by permeating ever changing humans' various value systems. Should ethics be changed to really answer to/satisfy with contemporary people's thinking/value systems/needs, instead of rigidly observing traditional ethics?

If we accept human diversity as beautiful and go beyond that level, what would be the relationship between ultimate ethics and diversity-based situational ethics? Where would ethics be situated in humans' metacognitive domain? Can we still recognize/have room for some universal or ultimate ethics which is the right way of thinking? I still believe God has taken a "Wait and See" attitude with His patience by observing us to see how humans would behave throughout history.

I wish to further investigate how humans' ethics should be shifted to include the ultimate goal of co-existence with other animals to maintain the overall balance in the universe. Euthanasia would serve as a living illustration to constructively include all kinds of interpretations of social justice, a person's right, and universal ethics.

Singer argues bioethics which is independent from religion should help make decisions on the basis of creating maximum benefit to the people involved. In the Bible, three kinds of love are listed. Agape love, sacrificial love or the

ultimate or supreme level of love should exist as a concept of the best relationship not only as a Christian concept, but also as a stand-alone or genuine principle of ethics needed for the most precious human relations. I wonder how both of bioethics-based maximum benefit and agape love would relate to each other in order to solve the problems about euthanasia.

I hope a non-profit and interdisciplinary research center focusing on current euthanasia in the world would be established as soon as possible for the following purposes: to educate both patients and doctors/medical professionals on the patients' ever changing physical/mental situations, patients' rights, living wills, alternative treatment/care, medical ethics, bioethics, and all animals' maximum benefits.

APPENDIX 1. **SPEECH AND/OR PRESENTATION CHECKLIST**

Argument

Purpose (appropriate and effective)
Excellent Good Fair Poor
suggestions: _____

Clarity (rationalized, consistent, and credible)
Excellent Good Fair Poor
suggestions: _____

Fact (relevant and clearly explained)
Excellent Good Fair Poor
suggestions: _____

Structure

Beginning (generate interest with focus, establish rapport)
Excellent Good Fair Poor
suggestions: _____

Main part (logical, clear and convincing transitions)
Excellent Good Fair Poor
suggestions: _____

Audio/Visual Aids (interesting and effective)
Excellent Good Fair Poor
suggestions: _____

Conclusion (debriefing well with some next steps mentioned)
Excellent Good Fair Poor
suggestions: _____

Delivery

Voice (tone with projection, pause, and pace)
Excellent Good Fair Poor
comments: _____

Body language/Physical presentation (Mannerisms and poise)
Excellent Good Fair Poor
comments: _____

Eye contact (respond for creating interest and rapport as well)
Excellent Good Fair Poor
comments: _____

APPENDIX B. TEN LESSON PLANS

Lesson 1. Is there such a thing as a *Good Death*?

Reading materials:

#1. Frame, D. 1957. The Complete Works of Montaigne. Stanford University Press.

"33. To flee from sensual pleasures at the price of life": 161-162.
"38. How we cry and laugh for the same thing": 172-174.
"6. Of practice": 267-275.

#2. A handout of Clark, M. 1995. An Aquinas Reader. New York. Fordham University Press.

#3. A handout of the Bible (the golden rule). In Bowie, G., Michaels, M. and Solomon, R. (eds.), 1996. Twenty Questions: An Introduction to Philosophy. Third Edition. Harcourt Brace College Publishers. Fort Worth.

#4. Longfellow, H. 1979. "A Psalm of Life." in Guttesman, B. et.al. (ed.) The Norton Anthology of American Literature. New York. W.W. Norton.

Objectives:

- Content: What are the two main different approaches taken so far?
- CCT: Analyze why human beings started to challenge God.
- Role-play: Listen to others' ideas to see what reasons are embedded.

Brainstorming: Ask students: "Have you thought about *who created our world* or *who controls our mother nature*? Have you ever prayed to God? If so, when and why? Have you considered seriously about life-and-death issues?"

Questions:

#1. Ask your students to work in small groups, to fill in below:

	Explanation of content	your comments
1) Greek gnomic poets (161):	_____	_____
2) Seneca's advice to Lucilius (162):	_____	_____
3) Montaigne's idea of one's feeling (174):	_____	_____
4) Canius Julius's last word (267):	_____	_____
5) Montaigne's *to-know-oneself*:	_____	_____
6) Aquinas's thought to God:	_____	_____

#2. Let the students stay in their small group and answer to the questions below.

	Aquinas	Montaigne
1) Is God's existence verifiable?	_____	_____
2) What is human's ultimate desire to life?	_____	_____
3) Who is responsible for human's end of life?	_____	_____

#3. Discuss in a whole class: "Why have humans had two different approaches?
One approach is based on _____, because _____.

The other is _____, due to _____.

#4. On Longfellow's poem called *A Psalm of Life*, discuss with your group members on the following points:

- How does this poem present life-and-death problems? .....
.....

- Which part of the poem would you agree/disagree most? .....
.....

- Create your own poem on life-and-death issues below.

....

....

Role-play #1. Is euthanasia an oxymoron?

June, Taro, Tom, and Ichiro exchange their opinions on the *nature of euthanasia,* or there may be no such *good death.* After discussion through a role-play, you are expected to fill out the form called *summary sheet* to check any similarities and/or differences shared in your group. A debriefing session is followed in a whole class on each group's outcome.

Ms. June Dickinson: You are Ms. June Dickinson. When you were a teenager, you attempted to kill yourself, because your parents said, at your 15th birthday party, "We are not your biological parents." What triggered them to mention that just as the party was approaching the end was your confession that the most precious vase of your parents' personal china collection was dropped out of your hands when you were moving the coffee table in your guest room. Now you are a college student and became a born-again Christian last year, accepting God as the supreme priority in your life.

You think the crux of death/euthanasia relates to how to define our humans' lives in terms of quality. You talk to yourself, "I'll be able to meet God once I am dead. Therefore, death is not the end of my life, rather it is a continued part of my life including eternal life beginning right after death. I live in a huge continuum in which my present life is located at the extreme end of one side, and eternal life at the other extreme end of the same continuum."

Why have humans become so arrogant challenging God and neglecting the Old Testament? You hate secular religions, because they are spiritual junk food. Last Sunday, the wife of a pastor said, "God is more faithful than my husband." You wondered if you had heard her words correctly. Was she joking around? You never expected to hear such expressions from the pastor's wife. You just think, "How does her 45 year-marriage relate to the construction of faithfulness between the two persons?"

Mr. Taro Yamada: You are Taro, a Japanese graduate student. You have just finished reading *An Aquinas Reader* on Thomas Aquinas. You are impressed by Thomas Aquinas's belief that nobody should commit suicide, because: (1) human beings are born to live, not to kill themselves, (2) suicide makes other people feel bad, and (3) human beings should never act as God, because God only has the right to decide whether a person shall live or die.

You believe in the existence of God as a creator of the universe, even though you're not a Christian. You have a long way ahead of you becoming a matured and well prepared person for end of life issues which you hope to face without fear, but with serenity.

You miss your grandparents, particularly, grandmother who said, "My mother-in-law and I developed mutual trust while sharing domestic chores." You wonder if your grandparents would live in Heaven. What would that look like? What do they do there? You want to chat together again. God, please tell me the number to dial!

You've been thinking about: (1) What I learned from my grandparents' death is life is very short, and the present life would be a shadow of death; (2) What is an eternal soul? Or if I have a soul, where it will go with me after death; and (3) in case of no such a thing as *good death*, how can I make my present daily life more meaningful? In a nutshell, except for the specific reasons/evidences accepted in Japanese cultural norms to rationalize suicidal actions, nobody should kill himself making all family/relatives face the most shameful circumstances in our culture.

Mr. Tom Salinger: You, Mr. Salinger, teach science at a high school in Boston. You are related to Salinger, the writer, who is alive in his seventies.

Your hunch is that euthanasia is an oxymoron, because "Death brings no constructive things! Or there is nothing constructive about death!" Death makes everything disappear or be in vain or worthless. Therefore, no good death exists or there can be no good death. You prefer to think Life is like sunrise, while, Death is like sunset.

Although your parents wanted you to become a CPA specialized in health care in order to open a joint-office with your elder brother, a CPA, specialized in tax transaction, you majored in Earth Sciences at college. Therefore, you highly value scientific thinking along with any evidence-based objective thinking processes. You are very much interested in various sorts of evolution theories. However, you know even the greatest scientists or world famous scholars in history cannot prove what the origin of the universe is. In other words, they have to admit their limit or ceiling. They need God to solve the conundrum of our universe.

You truly believe that there is no such expression as *rational suicide.*

Mr. Ichiro Suzuki: You are Japanese and your name is Ichiro. You and Taro were members of a group called "Current English Club" when you attended the same college in Tokyo. You have been working for a leading publishing company in Tokyo. Recently you came across some essays written by Montaigne, when your department decided to begin introducing European historical thought to Japanese adults. You read Montaigne's essays and became interested in his ideas, i.e., suicide is considered as a matter of personal choice. You think if a person really wants to die, suicide would be a good death as the person's best choice. You feel empathy with those who commit suicide, because they might have experienced a terribly sad life.

Your mother has taken care of your grandmother at home for more than two years. Therefore, no one in your home wants right now to talk about death or euthanasia, because the issue is not appropriate. Elderly Japanese much prefer to die at home on their *futon* under their family members' care.

"Am I a product of the ME-GENERATION?" you murmur, "Given that I may become ill or disabled myself someday, I wonder whether or not an individual should have the right to choose euthanasia if his quality of life is destroyed. Is that so selfish?"

Let's jot down a *summary* of each participant below:

Parties	**June**	**Taro**	**Tom**	**Ichiro**
Perceptions: (Tendency to see the world)	_____	_____	_____	_____
Interests: (What you really want)	_____	_____	_____	_____
Fair reasons: (Rationalized thinking/solution)	_____	_____	_____	_____
Options: (Possible choice)	_____	_____	_____	_____
Similarities: among members	_____	_____	_____	_____

Any consensus reached? .....

*Your comments:

*This includes any evaluation of all the participants: your own and the three members for your reference.

Lesson 2. How are *pleasure and pain* defined in the latest bioethics?

Reading materials:

#1. "Professor Pleasure or Professor Death?" 1998. Sept. 25. The Wall Street Journal.

#2. "Letters to the Editor: Practical Ethics." 1998. Oct. 15. The Wall Street Journal.

#3. "Tempest Over Princeton Teacher." 1998. Nov. 29. The New York Times.

#4. Singer, P. 1979. Practical Ethics. First Edition: 51-52.

#5. Singer, P. 1993. Practical Ethics. Second Edition: 105.

#6. Iggers, J. 1998. Good News, Bad News: 109.

#7. "Princeton's New Philosopher Draws a Stir." 1999. Apr. 10. The New York Times.

Objectives:

- Content: How bioethics relates to traditional moral values.

- CCT: Compare the descriptions of Singer's ideas and develop insights into how to recognize the media's skewed information.

- Role-play: Try to look at your ideas from other's point of view.

Brainstorming: Ask students: "Do you believe all the news in the newspapers? How can the media manipulate innocent readers by reporters' insufficient information? What strategies should you develop not to become the victim of a reporter's misinterpretation?"

Questions: Discuss in small groups and share in a whole class later on.

#1. On the article on Sept. 25, 1998, what expressions did Ms. Schaefer use on Singer's ideas of euthanasia in terms of human being's pleasure and pain?

I have noticed that she wrote ....., because .....

#2. On Prof. Singer's response on Oct. 15, how many examples of "a gross misrepresentation of my position" can you find?

Write your *correction* below.

1) the heading of the article: _____.
2) how a mouse's life relates to philosophy: _____.
3) How pleasure relates to criteria of life: _____.
4) Unhappy person's death increases the overall sum of pleasure: _____.
5) Handicapped people are to be killed: _____.

#3. Write Singer's *satire* on Schaefer's reporting.

1) his photo: .....
2) her grasp of his undergraduate text: .....
3) Life-and-death discussion in the US/Princeton:.....
4) The writer's task: .....

#4. Complete the following paragraph on what you learned from Singer-related interaction by the newspaper.

I can learn fortunately (1) _____ and (2) _____, but at the same time I recognize _____ in English newspapers, because in Japanese newspaper, we have historically _____. I hope Japanese media will be able to take _____.

#5. Compare the descriptions of the articles between Nov. 29th and Sept. 25th.

Description	Nov. 29th	Sept. 25th
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

#6. How can you separate *pain* from *pleasure* between animals and humans?

Write your comments below:

	Pain: when you noticed.	*Pleasure*: when you noticed.
Animals: (i.e., a dog or a cat)	_____	_____
Humans: (you, your loved one, and/or others)	_____	_____

#7. Create a letter to Singer, as if you were Ms. Schaefer.

Date:

Dear Dr. Singer:

Regarding my article, I would like to _____ _____. I feel extremely _____.

In the meantime, I wish to _____.

Once again, I deeply _____.

Best regards,

Your name and signature

#8. Read the article dated April 10, 1999. If you interview Singer, what questions would you like to ask and why?

Your questions:	Reasons *WHY* you want to ask.
1) How .....?	.....
2) What .....?	.....
3) When .....?	.....

Role-play #2. What are *pleasure and pain* in bioethics?

The following four people will discuss about human's pleasure and pain in bioethics.

Mr. Peter Edwards: You have read Dr. Singer's *Practical Ethics*. You just wonder how pleasure and pain really relate to euthanasia. Singer claims ethical judgments based on a universal point of view provide a persuasive reasons for Utilitarianism. In order to increase pleasure and reduce pain, Utilitarianism measures all interests and adopts the best decision aimed at maximizing the interests of the people involved. Singer suggests if we use the universal aspect of ethics in our daily decision making, we can exercise a utilitarian idea.

Singer thinks euthanasia of terminally ill patients should be justified because of their pain. You watched John, one of your friends or your next-door neighbor, who struggled with bone cancer and then passed away. Therefore, you feel sorry for the various kinds of pain experienced by patients and their families. Consequently, you agree with Singer that comatose patients should receive euthanasia.

You think The New York Times' reporter was good compared with The Wall Street Journal's intern whose incorrect reporting made her unqualified.

Dr. James Harby: You are the founder/president of Christian Family Organization for 20 years. You are extremely surprised to read The Wall Street Journal's article dated Sept. 25, 1998, reporting that Prof. Singer was accepted as a faculty member of Princeton University. What criteria were used for Princeton's faculty? Princeton should have the high mission to maintain traditional moral standards rooted in western Christian values.

The article includes the following statements: "If handicapped people have lives that aren't pleasurable, Singer stands ready to have them killed," "No compromises for traditional notions of morality," and "The overall sum of pleasure will be increased when an unhappy person dies." You think these statements miss the points that our life has been given by God. Nobody should act as God. Life is God's loan/gift to us! You want to know: (1) *what is true human happiness* and (2) *which is good or bad* should not be measured merely by *pleasure or pain*. *Pleasure and pain* must not be used for the reasons of simply justifying euthanasia.

You also have to admit American people nowadays are terrible because they never care *what is right and what is wrong.*

Ms. Barbara Cronkite: You have been working for *Usa Today* as a reporter for more than 20 years. You've read the three articles: the two of *The Wall Street Journal* and one of *The New York Times*, and think *The Wall Street Journal's* reporting is totally incorrect. Having read Singer's two books: *Practical Ethics* and *The Expanding Circle: Ethics and Sociobiology*, you've gotten interested in the universal aspects of ethics and animal altruism. Since human beings are social animals, the reciprocal altruism of other animals could work for humans' reciprocal altruism and social contract model of ethics. Given our current state of moral bankruptcy, other animals might laugh at us if they could share language with us. Young adults in the 21st century should value fairness and impartiality by taking advantage of human's diversity in our world village. Moral concerns and social skills should be taught at home by parents, but not in order to defeat others' ideas.

You just wonder if Washington Irving slept more than 200 years and suddenly awoke in 1999, What would he think of modern media reporting? Because you respect Washington Irving as *the first American man of letters*, along with his created characters, i.e., *Rip Van Winkle*, Americanized version of German folktales, with a henpecked husband sleeping for 20 years and awaking as an old man and finding his wife dead, his daughter happily married, and America now an independent country.

Ms. Sakura Endo: You're an English teacher at a senior high school in Tokyo. You worked for *The Japan Times*, the oldest English newspaper in Japan, for three years. Your role is to confess the following: Our society maintains both: hierarchy of traditional social status and highly valued official aspects compared with any unofficial/informal aspects. As far as I know, even a smart college graduate who has just joined a leading newspaper can be seen by other experienced staff as an object of "Wait and see." Japan has no intern systems, regardless of a company's size and/or function. Any new comers are anticipated to have acquired Japanese traditional common sense under the guidance of their parents by the time they begin to work for an organization. Common sense among managing staff members of organizations is to take a "Wait and See" attitude for a long time to any new comers, while the organizations invest money/time for their training in order to really raise acceptable staff members for the future of the organizations. Generally speaking, no staff of any editorial section has the courage to put just a new comer's work into tomorrow's newspaper, because nobody wants to be criticized by his senior staff and/or the president of the organization. We, Japanese, are all coward social-creatures who are afraid of being seen as *one sheep* out of ninety-nine sheep. My point for further discussion is that: Where should we draw the line to distinguish between a new comer's work and already working staff's work based on What kinds of criteria?

Prior to debriefing in a whole class, jot down a summary of your group's role play.

Parties	**Peter**	**James**	**Barbara**	**Sakura**
Collaboration: (Working together)	.....	.....	.....	.....
Interests:	_____	_____	_____	_____
Perception:	----------	----------	----------	----------
Fair reasons:	_____	_____	_____	_____

Any consensus reached: ----------

Look reflectively at your attitude taken today and jot down below:

.....
.....
.....
.....
.....
.....
.....
.....
.....

Lesson 3. Which comes first regulation or your personal choice?

Reading materials:

#1. "Nancy Cruzan, R.I.P." 1990. Dec. 28. The Wall Street Journal. Editorial.

#2. "To Die with Dignity." 1991. Jan. 7. TIME: 59.

#3. Tifft. S. "Life and Death After Cruzan." 1991. Jan. 21. TIME: 67.

#4. "When can a doctor kill?" 1993. Apr. 27. The Times.

#5. "Old Law, new medicine" 1993. Feb. 5. The Daily Telegraph.

#6. Camhi, L. "Before and After." 1998. Apr. 28. Village Voice.

#7. "Life is Precious, No Matter the Quality." 1998. Jan. USA TODAY: 9.

#8. "Deadly Compassion." 1997. Jun. 16. CHRISTIANITY TODAY: 14-21.

Objectives:

- Content: Classify active/passive euthanasia and PAS (physician Assisted Suicide). Make a list of four aspects together with Japanese counterpart.
- CCT: Scrutinize why euthanasia and PAS are similar/different.
- Role-play: Understand others' feelings behind the words said.

Brainstorming: Ask students: "Have you ever seen tragic accidents? Have you personally got involved in any accidents? Let's think about why we cannot stop accidents."

Questions:

All questions are answered individually and discuss in a whole class later on.

#1. Fill out words below, by referring to reading materials:

	WHY kept alive?	Legal issue	Moral issue	Common conscience
Nancy Cruzan:	_____	_____	_____	_____
Anthony Bland:	_____	_____	_____	_____
Your comments on the above two cases	_____	_____	_____	_____

#2. On the *Times*, Apr. 27, 1993, how can we raise awareness of "which decision best respects the sanctity of life"?

#3. On *The Daily Telegraph*, Feb. 5, 1993, who would be responsible to narrow the gap between old law and new medicine?

#4. How could Anthony Bland's tragedy enlighten people to feel his family's pain?

#5. On "Before and After," if you could interview the two directors, what kind of questions would you like to ask?

#6. What is you opinion on "Life is Precious, No Matter the Quality"?

#7. Write a letter to Nancy Cruzan's family with your personal comments by using the form below:

Date

Dear Mr. and Mrs. Cruzan:

Regarding your daughter, Nancy, I would like to _____.
_____. I could feel _____
because _____.

In Japan, _____,
Therefore, _____.

Please take good care of yourself.

Sincerely,

Your name and signature

#8. On "Deadly Compassion," fill in your comments with the description reported.

	Your comments	Description reported

1) Who are the Moral Theologians?

Medicine has lost its moral foundations.
Does medical ethics need input from religious traditions?

2) Who are the Medical Ethicists?

PAS is a shortcut on legitimate concerns in illegitimate ways.
PAS as doctors' option would be disastrous for patients.
Is PAS a non-compassionate form of moral abandonment?

3) What is a lawyer's idea?

Is PAS a civil-rights or moral issue?
Must coma patients' *right-to-die* be exercised by proxy?

4) What is a geriatrician's view?

Is PAS immoral?
How to validate the humanity at end of life?

Create Japanese translated version of the above four classifications and then think about how the four categories work as the counterpart in Japan.

	Japanese translated words	How they function in Japan
Moral theologians:		
Medical Ethicists:		
Lawyers:		
Geriatricians:		

Role-play #3. Which one's intention is honored?

John, Tina, Sayaka (a Japanese college student), and Anne are supposed to discuss on how we can rationalize/prioritize between (1) intention and (2) action in relation to active/passive euthanasia and PAS.

John: You are right now thinking about Passive euthanasia, Active euthanasia, and Voluntary Active euthanasia.

You are a grandson of Mrs. Johnson. This coming weekend, you are going to visit your sick and lonely grandmother who has been hospitalized since 1995. You would like to make her feel good. Your grandmother is a wonderful lady, because she always loves to talk about her own views on the various characters of Shakespeare's work and the latest worldwide and/or domestic news on TV. You have a slight idea that your visit might influence her making her will in your favor.

You prefer passive euthanasia to active euthanasia, because to let terminally ill patients go or mercy killing would be acceptable if someone in comatose condition faces end of life problems.

Tina: You'll visit your sick grandmother at a nursing home during the up coming holiday to spend some time together chatting about your family members and relatives living in other countries. However, you assume she will write her will because (1) her health has gotten worse and (2) she is such a well-prepared person in her concerns. Therefore, you want her to include you among her heirs.

You watched many documentaries on TV on terminally ill patients' family concerns. They confessed lots of problems on decision making processes, because they could not ask their loved one about what kind of treatment the patient truly wanted to receive either in the midst of pain or at their final stage. The patient might have changed his/her mind through experiencing various treatments. However, s/he had no time to tell anyone or could have no ability to communicate by the time s/he really wanted to convey the message across. Having imagined the above mentioned changing feelings of their loved one, family members were always struggling with unexpected situations of the patient throughout the treatment. They recognize an uncontrollable factor, time, which is going on relentlessly, regardless of how much they pray to God to mitigate the patient's pain/agony, asking reasons why they all had to go through such terrible and heavy turmoil, and/or hating God because God cannot prevail against the evil thing called *death.* They had to decide seemingly the best choice for the patient based on their family-initiated consensus, not the patient's own final decision. Accordingly, you agree to active euthanasia for reducing both the patient's pain and their family's tangible and/or intangible burden.

Sayaka: Right now your grandmother is hospitalized, therefore, you want to say "Hi!" to her tomorrow. You also wish to enjoy conversation with her exchanging ideas on "What is life all about?" You remember an interesting conversation between you and her. When you said to her, "You must have been a pretty girl when you were young," she said, "You know everything is subject to change, especially our skin when we get old. Even though I am exactly the same person and want to be a life long learner, I often forget these days. Listen! Before I forget, I must tell you I feel proud of your mother who is taller and more pretty than I am." You were amazed to know how grandmother evaluated herself in comparison with her own daughter. She continued, "I have no idea when God will come to take me out of the present world, but I wish to live as long as God accepts me to do so." You changed the topic and said, "I watched T.V. last night on euthanasia in the U.S." She said, "I did too. In Japan, people tend to accept mercy killing as I've heard lots of experiences, but active euthanasia is not welcomed, I believe, based on the general cultural climate in Japan."

Anne: You're Anne, an English Accountant for 20 years in London, U.K. When you were standing at the platform of Piccadelly Circle, one of the tube stations in London to change the lines, you happened to see one of your aunts when the door of the subway opened just in front of you. You both got surprised to come face to face in the middle of the tube. You instantly thought, "Is this God's plan?" She said, "I Got a call from police ... Your mother was involved in a car accident ... I'm going to visit the hospital right now." Since then, you've been taking care of your mother by quitting the job and now teach part time some Accounting courses at a college. Recently your mother's situation has deteriorated, and you have to find another hospital to make her situation better in the near future. However, you hate to think of either passive and/or active euthanasia, because the results of the two kinds of euthanasia seem to eventually be the same, except for the difference of the means/process. You wonder what the alternatives for euthanasia are. What is the best way you can show how much you respect, appreciate, and love your mother from the bottom of your heart? Tomorrow you'll check up the telephone numbers of hospice facilities in the greater London areas.

Let's compare similarities and/or differences in the following chart:

Parties	**John**	**Tina**	**Sayaka**	**Anne**
Idea of Passive/active euthanasia:				
Other Interests:				
Rational reasons:				
Options:				

How have you been enlightened by the role-play on euthanasia?

Before winding up this lesson, let's create a complete sentence based on your experience right after the following expression, "Whenever I visit a hospital, I feel ....."

Then share with your group members.

Lesson 4. Regulation vs. a family's personal choice

Reading materials:

#1. "A Life in the Balance." 1975. Nov. 3. TIME:52.

#2. " Sentenced to Life." 1975. Nov. 24. TIME: 70.

#3. "Before Karen's Coma." 1975. Dec. 29. TIME: 19.

#4. "Losing a Son and, Finally, Burying Him." 1998. Jan. 11. The New York Times: 14NJ.

#5. "Taking charge." 1997. Jul. 28. US NEWS & WORLD REPORT: 56-68.

Objectives:

- Content: Investigate the reasons why the patients were kept alive.
- CCT: Think alternatives they might have taken.
- Role-Play: Develop empathy to others, while you try to understand their problems.

Brainstorming: Ask students, "How much can you read reality behind the reported scenes on the newspaper/TV? Have you tried to comprehend any articles while applying the following two aspects at the same time: (1) empathy and (2) Critical and Creative Thinking?"

Questions:

#1: Suppose you were Karen, Steve or Jason, how would you like to express your own opinions/feelings to your family on their treatment/decision?

Provided you were:	Your words	Reasons why you said so.
Karen:	_____	_____
Steve:	_____	_____
Jason:	_____	_____

#2: What kind of stress could you imagine among their family members?

	physical stress	mental stress	solution to stop stress
Suppose you were:			
Mother:	_____	_____	_____
Father:	_____	_____	_____
Brother/Sister	_____	_____	_____

#3: What should be the true contribution of a respirator at the end of human life? Or How many options should be thought about before simply operating/stopping a respirator?

	RESPIRATOR's Operation		
	When to start	When to stop it	Alternatives
If you were a doctor,	_____	_____	_____
a patient,	_____	_____	_____
his family member,	_____	_____	_____

#4. What is your opinion of removing decision making from mainly a physician to the hand of law? Or How does treatment relate to legal regulations?

	If Medical power increases	If law gains power
Reality in cases mentioned:	_____	_____
Your opinion:	_____	_____
Future perspective:	_____	_____

#5. On Steve's case, what sort of different attitudes between his mother and father have you perceived from the article?

#6. Make one compound sentence for each issue below, beginning with explaining the meaning written in reading #5, *Taking charge,* and then finishing the sentence with your comments. For example, Since **X** is defined as **Y**, I agree, disagree and/or think about **Z**.

1) freedom to make the wrong choices: _____.

2) right to refuse care: _____.

3) right to die: _____.

4) doctors' ignoring patients' preferences and/or living wills: _____.

5) resuscitation:_____.

6) Do-not-resuscitate bracelets: _____.

7) Psychiatric care: _____.

8) Hospitals' ethics committee: _____.

9) Bioethics panel: _____.

10) Pain management: _____.

11) Lack of knowledge among American doctors: _____.

12) a ventilator and other machines: _____.

Then, discuss with your partner, in your group, and share in a whole class later on.

#7. Situational examples below are discussed in a whole class for solutions.

Situation #1: You, in a coma state due to the accident 10 years ago, have been in many different hospitals. Current doctors and psychiatrist have no slim hope of regaining consciousness. How would you like to be treated? Your better half visits you everyday, but you feel nobody visits your room in the hospital.

Situation #2: You have bone/stomach cancer for five years making you hard both to move and to eat. Your family rarely comes to see you, because your ex-husband has remarried and your kids, already grown up, have been working in other states. Recently your doctor considered you as a terminal ill patient, but no way to make your family know about it. You have no memory nor words clearly understandable. Can you rely on the doctor and ask him choose your end of life?

Situation #3: You have brain damage due to an airplane accident. You are unable to recognize even your doctor or nurses. You have no terminal illness so that you may live in this condition for a long time. What would you like to be treated from now on? You have the family of three teenagers who are busy on their own business. Your husband is now trying to separate from you. However, you have an old friend to whom you told about your wish of end of life. To whom would you like to ask your final direction?

Treatment Options are: 1st treatment (mechanical breathing), 2nd treatment (artificial nutrition and hydration), 3rd treatment (chemotherapy by drugs used to fight cancer), and 4th treatment (pain medication causing dull consciousness and hasten death).

	Which treatment used from the four above	Your reason for the choice taken
Situation #1:	_____	_____
Situation #2:	_____	_____
Situation #3:	_____	_____

Role-play #4. Who decides to stop a respirator and when?

On the above issue, students with roles below are expected to exchange views.

Mr. Smith: You, Mr. Smith, rushed to the hospital to which your wife was taken by ambulance after having involved in a traffic accident in December, 1985. The doctors in the emergency room of the University hospital diagnosed that Mrs. Smith urgently needed brain surgery. It took seven hours to finish her first operation. Then she was moved to the ICU (Intensive Cure Unit) for 24 hours. After that, she had to experience two more brain surgeries before she could open her eyes by herself. Mrs. Smith stayed in the hospital for more than twelve years without recovering her consciousness. You and your two teenage children, Patricia and Erica, have been visiting the hospital everyday. Recently, Mrs. Smith's condition with a respirator worsened. She began having violent shivers every 20 minutes. You have been very much worried about her current condition and tried to talk with her doctor, Tina Jones, about how to alleviate her pain caused by the violent shivering episodes. Yesterday, Dr. Jones said, "I've tried all I could based on the latest medical treatment. I feel terribly sorry for her, but how much pain she has is hard to measure since there is no interaction." You think about what is the best way to maintain your wife's dignity as a human being on the verge of life and death. You remember when all of your family were watching the TV program on terribly brain damaged patients and their families' difficulties. Your wife said, "Oh, I cannot stand such a situation! You hate to hasten her death, but have to admit the best solution would be to cut the machines and let her die with dignity. A meeting with Dr. Jones is tomorrow.

Dr. Ester Franklin:

You are Dr. Ester Franklin. You have more than 20-year experience in a major university's hospital in the U.S. You go to church every Sunday. One of your concerns over the past 20 years has been about end-of-life care. One of your patients, Mrs. Smith, unfortunately got involved in a traffic accident and was taken to your hospital in December, 1985. The doctors in the emergency room of the university hospital quickly diagnosed that she urgently needed brain surgery. It took seven hours to finish her first operation. And then she was moved to the ICU (Intensive Cure Unit) for 24 hours. After that, she had to experience two more brain surgeries, before she could open her eyes by herself. She has been hospitalized for more than twelve years without recovering her consciousness. Her husband and her children, teenagers, have been visiting the hospital everyday. Recently, Mrs. Smith's condition got worse because of being suffered every 20 minutes from severe shivering symptom. You have been very much worried about her current conditions and tried to talk with her family about how to remove her pain from shivering every 20 minutes. You need to further try any possible solutions to help her situation, even though you have done everything you could think of. You should discuss with her husband and her two teenage children whether or not they feel comfortable in using pain relief medicine for her. You believe religiously, emotionally, intellectually, and morally that a human being should have every possible chance for living.

Grandmother: You are the mother of Mrs. Smith. Everyday you see your daughter at the hospital. You deeply recognize there is a big difference between learning through the media someone got involved in an accident and personally getting involved in any accident followed by family members' hospitalization. You wish you could change places with your daughter. You want to talk with her doctor along with your son-in-law, Mr. Smith. You have mixed feelings: you want your daughter still alive with the help of the respirator, but you cannot stand to see her suffer. Your question is, "What does 'Enough is Enough' really mean? How should it be applied to what she would want, if she could have said, and satisfy my feeling or responsibility as well?"

Patricia and Erica: You both are very much concerned about your mother's condition. Patricia adopted at the age of seven is the known fact. Therefore, both of you have had pretty much the same feeling toward your mother. You hate the taxi driver who caused the accident. You hate to see her suffer. You want her alive without any pain. If she goes, you both want to die together!! You do not want to believe in God, because God is not fair to make your best loved one disappear from this world. By now, you recognize stopping the respirator means making her die. Who could invent the medicine to solve double effect? Someone who could invent it would surely win the Nobel Prize! Your question to her doctor is "What are the alternatives to ease her suffering and prolong her life without the respirator's help?"

Fill out the form below at the end of your role-play, and then discuss in your group, and in a whole class later on.

Parties	**Mr. Smith**	**Dr. Franklin**	**Grandmother**	**Patricia & Erica**
Fact:	.....	.....	.....	.....
Wish:	.....	.....	.....	.....
Solutions:	.....	.....	.....	.....
Options:	.....	.....	.....	.....

Any consensus reached: .....

Or No solution reached, because .....

Lessen 5. Who tells the fact of *Assisting* suicide/euthanasia?

Reading Materials:

#1. Young, R. 1988. Jan. 8. "It's over, Debbie." JAMA, The Journal of the American Medical Association. 259 (2): 272(1), and related articles: Lundberg, G. 1988. Apr. 8. "It's over, Debbie and the euthanasia debate." JAMA: 259 (14):2142(2), and Vaux, K. 1988. Apr. 8. "Debbie's dying: mercy killing and the good death." JAMA. 259 (14): 2140(2).

#2. Clark, M. 1995. "Friendship and Freedom." An Aquinas Reader. New York. Fordham University Press.

#3. Riddell, M. 1998. Oct. 2. "Mary Riddell." New Statesman: 14.

#4. Hentoff. N. 1998. Feb. 17. "How To Commit a Loving Murder." Village Voice: 22

#5. Driedger, S. 1998. Mar. 9. "Everyone knows it happens." MACLEAN'S: 50-52

#6. DePalma, A. 1998. Nov. 24. "Light Sentence In Mercy Death Is Overturned In West Canada." The New York Times: A8.

#7. "What it Mercy or Murder?" 1998. Oct. 17. The New York Times: B1/B5 (another copy with a bit different reporting).

#8. "Hospital Ousts 4 More After Inquiry on Deaths." 1998. Apr. 4. The New York Times: A9.

#9. "Hospital Worker Recants Confession on Killings." 1998. Apr. 9. The New York Times: National Desk: 23.

Objectives:

- Content: Compare different conditions assisting suicide/euthanasia.
- CCT: Seek similarities/differences hidden in different articles.
- Role-play: Search for any consensus on no help provided for someone to die.

Brainstorming: Ask students: Have you felt empathy to someone who committed suicide? If so, Why? Have you ever tried to kill yourself? If that is the case, what made you think so?

Questions:

#1. On reading #1, if you were the investigator for Debbie's case, what kind of questions you want to ask to the following persons? Write your questions, then discuss in your group and a whole class later on.

- To the doctor: _____.

- To Debbie's parents: _____.

- JAMA's editor: _____.

#2. On reading #3, by referring to Aquinas's article, what is your opinion on Beadle's having assisted his old friend's suicide?

#3. On readings of #4, #5, and #6, if you were in that situation, how could you act to reduce your loved one's pain, while taking risks against laws? Think on your own, then exchange ideas in a whole class.

#4. On reading #7, how should doctors be trained on the following issues?:

1) How to respond to patient's dying request: _____.

2) What are their *permissible* actions?: _____.

3) How should they be taught on *intention*?: _____.

#5. On readings of #8 and #9, what sort of changes must be done for the hospital workers?

Role-play #5. How can you justify helping someone die?

David, Sara, Mary, and Steve are thinking together about any guidelines for not assisting suicide.

David: you're David and a leader of teenagers at a non-profit organization in Boston. You've been thinking about what are the criteria to say "NO," to someone who asks you to help end of his or her life. You think the following two factors are very critical prior to your decision whether to help someone die or not: (1) how does your philosophy of life relate to a person wanting to die and (2) the quality of relationship between the person and you. But, you personally prefer to persuade the dying person, rather than trying to dissuade.

You have a brother, Tom, who dropped out of high school and has right now alcoholic problems. Your parents have gone, and you want to help him come back to high school to wind up his final year for graduation, without his rushing to commit suicide. You know that every kid wants to be loved and get involved in a warm atmosphere, say, a family night. Even rebellious kids want to have a relationship over breakfast, lunch, or dinner discussing their parents' own experience with failures/mistakes helping kids talk. Kids will never forget that kind of discussion time.

Sara:

You are a social worker in Boston and have often been asked from many homeless people, "Can you help me die?" Whenever you are asked, you stop a few seconds and ask yourself, "What would I do if I were this person?" Or "What is the appropriate behavior/action to make this person feel comfortable and then find some meaning in life?" Or "How could I help to develop their self esteem?"

You struggle with facing these people, and murmur, "What can I do to encourage them?" "How can I remove the obstacles they face?" In your mind the crux is to figure out what makes them stumble in their lives. Your bottom line without forcing them to reveal their private matters just for your understanding is that you *cannot* say, "Well ..., your problem is ... your own responsibility! Don't include me! See you."

You believe any person including doctors should not help to die unless a relationship (friendship or love) and mutual respect are already established.

Mary:

You, Mary, are a teacher and have a good friend whose name is Linda. Linda's mother was killed in an airplane accident last month. Your present concern is how to cheer Linda up and then how to stop her from committing suicide. You once envied her because of the wonderful and close relationship between Linda and her mother when she was alive. You ask yourself, "What is *the limit* for me to make Linda feel comfort?" The reason why you think of the limit is that thousand words mean nothing, unless you can genuinely encourage Linda to find her life meaningful, because no one's life is accidental and meaningless. But, at the same time, you recognize only *time* will be able to heal her grief. In other words, it will take at least one year for her to recover from her mother's death. Therefore, probably next year, you would like to tell Linda that one of proverbs, "Every cloud has a silver lining," is not merely an old fashioned expression, but that saying should be applied to all of us including Linda. You believe nobody should help one's suicide as the *extension of friendship*.

You have a penpal in Tokyo whose name is Shiori. You were puzzled by her recent letter saying that she could not commit suicide, although she had seriously thought about it, after her husband-to-be was killed in a traffic accident in Sydney, Australia, where he was planning to open a Sushi restaurant as an affiliate of his father's supermarket in Tokyo. Her main reason is rooted in Japanese culture in which suicide reflects badly on her family and relatives humiliating the family name and social status.

Steve:

You are Dr. Steve Washington. You have been working for 20 years as a home doctor visiting individual patients in their home. When a patient faces his/her end of life, you have been asked to give medicine to reduce pain. At that time, you always call other doctors or friends who have been working for adjacent hospitals/hospices. As patients always need various kinds of examinations before actually giving any additional treatment, you think the best medical care is offered, not at home, but by hospitals because of the latest facilities available. You have problems about how to convince your patients. Their question to you is "Why should I move to any hospital? What's wrong with being cared for at home?" You believe that, *without mutual trust*, anyone even *physicians should not help to die*.

Last week, you happened to meet some foreign doctors who came to attend an international conference and learned about cultural differences on suicide. For example, in Japan, no patients talk casually to doctors about their suicidal history in the past and any attempt in the future. The reason is that their relationship is hierarchical, official, and/or superficial. Or, there is no room to talk about patient's deeply hidden private matters.

Try to find the differences among the four people by using the chart below:

Parties	David	Sara	Mary	Steve
Active Listening (To pay maximum attention to What you hear)	.....	.....	.....	.....
Experiences:	.....	.....	.....	.....
Occupations:	.....	.....	.....	.....
Interests:	.....	.....	.....	.....
Fair reasons:	.....	.....	.....	.....
Any consensus reached:	.....	.....	.....	.....

Lesson 6. Physicians' attitudes to euthanasia/PAS in UK/Australia/USA.

Reading Materials:

#1. Shah, N., Warner, J., Blizard, B., and King. M 1998. Oct. 24. "National Survey of `UK psychiatrists' attitudes to euthanasia." THE LANCET. 352: 1360.

2#. Wehnwein, P. 1998. Aug. 15. "US physicians confused about end-of-life care." THE LANCET. 352: 549.

#3. Emanuel, E, Daniels, E., Fairclough, D., and Clarridge, B. 1998. Aug. 12. "The Practice of Euthanasia and Physician-Assisted Suicide in the United States." JAMA. 280 (6): 507-513.

#4. Stolberg, S. 1998. Apr. 23. "Assisted Suicides Are Rare, Survey of Doctors Finds." The New York Times: A1.

#5. Meier, D. 1998. Apr. 24. "A Change of Heart on Assisted Suicide." The New York Times: A27.

#6. Meier, D., Emmons, C., Wallenstein, S., Quill, T., Morrison, R., and Cassel, C. 1998. Apr. 23. "A National Survey of Physician Assisted Suicide and euthanasia in the United States." New England journal of Medicine. 338 (17): 1193-1201.

Objectives:

- Content: How doctors' lack of knowledge affects their practices.
- CCT: Why doctors badly communicate with patients and their family members.
- Role-play: Make sure what is the gap among participants.

Brainstorming: Ask students: "If you were a terminally ill patient, what would you ask your doctor? What level of interpersonal communication skill should doctors acquire during their internship in order to build trust relationship with patients and their family members in their medical practice?"

Questions:

#1. On reading #1, write your answers below:

- How would doctor's *degree of involvement* affect his choice between VAE and PE?

- How would psychiatrists advise mentally ill patients wanting assisted suicide? Will this contribute to developing the psychiatrists' skills?

- How would you speculate UK's direction on the legislation of assisted suicide?

#2. On reading #3, how do *the proposed safeguards* relate to consistency of practices of euthanasia/PAS?

#3. On reading #5, paraphrase in your own words Dr. Meier's change of thought on doctor-assisted suicide. Start your sentence with "I remember ..."

I remember that .....

- Make a list of *Seven implications* below together with your comments:

	Implications	your comments
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____
7)	_____	_____

#4. If you were responsible for arranging a manual called *Doctors' Training*, how would you like to emphasize on the following key issues?

- Doctors (Drs.) as good listeners: _____.
- Drs. to understand patients' pain: _____.
- Drs. as life-long learners thinking about and/or applying the results of the latest medical research for the benefit of your patients: _____.

- Drs. as sensitive persons to your patients' cultural aspects: _____.

#5. How could anyone possibly create/invent the medicine and/or care system to avoid the double effect?

	medicine	care system
1) to reduce pain:	_____	_____
2) to hasten death:	_____	_____

#6. On reading #6, how would doctors' following aspects affect their practice?

Write your reasons below:

Dr.'s race: _____.

Dr.'s religious belief: _____.

Dr.'s age: _____.

Dr.'s regional difference: _____.

Dr.'s gender difference: _____.

Dr.'s idea on palliative care: _____.

Any other factors you want to add? _____.

Role-play #6. Communication gap always between doctors and patients. The following four persons try to figure out how to avoid the communication gap between a patient/his family members and doctors. Both parties need to discuss patients' changing situations, treatment, and final stages without relying on their own assumptions.

Mrs. Johnson: You, Mrs. Johnson, have been married for 60 years. Your husband aged ninety-three has been hospitalized for one year. You said to his doctor, Dr. Lawrence, "Spare no expense. Please do everything necessary, such as, sending him to the ICU (the intensive care unit) if he should become critical." However, you got angry with the doctor's latest treatment, because in your mind *Everything* means all kinds of treatment including CPR (the Cardiopulmonary Resuscitation). You shouted to the doctor, "You have no right to play God when you decided not to try to save my husband. You think older people do not have a future. You cannot just save the young and not the old. Any doctor should be forced to save everybody, except those who don't want to be saved."

You've now realized you made a big mistake in selecting the right doctor for your better half. You should have asked Dr. Lawrence questions like "What kind of religious belief do you have?" or "How often have you asked your colleagues to get second or third opinions to help treat your patients?"

Dr. John Lawrence:

You are Dr. Lawrence and one of your patients is Mr. Johnson aged 93.

One morning, when you visited his room, Mr. Johnson said, "Am I all right, Doctor?" However, fifteen minutes later a nurse entered the room and found he was not breathing and had no pulse. On the nurse's request, you rushed to his room and made your decision not to call for CPR (the Cardiopulmonary Resuscitation) team and not to initiate CPR yourself. You could not figure out how many minutes Mr. Johnson had been out when he was found. You remembered an American medical expert's opinion written in the leading journals that old people experience brain damage within four to ten minutes following an arrest.

You also think it is criminal to try to resuscitate someone in Mr. Johnson's age group in order to prolong life a week at the most in his condition. You believe that nobody is supposed to live forever. Therefore, when someone gets to more than ninety, he is doing pretty good. Honestly speaking, your interpretation of Mrs. Johnson's *Everything necessary* does not include CPR.

Since you have been a medical doctor for more than 35 years, you have accumulated quite a lot of knowledge through various kinds of patients. Therefore, you have a strong confidence in your own insight and intuition.

Dr. Takashi Kato: You are a male physician as the head of a government hospital in central Tokyo. In Japanese hierarchical culture, a doctor is a prestigious profession. Patients always treat you with deep respect and humility, calling "Doctor Kato." On the end of life issue, you hate to tell patients' family members, "Your father is going to die shortly." Having heard a doctor's comment, Japanese family members *rarely* request or *even ask* what to do at the final stage. Doctors are supposed to take the initiative, i.e., to apply a respirator or not, without discussing it with the family members. You use ordinary medicine legally accepted and primarily not to hasten patient's death. Honestly speaking, since no data on euthanasia have been published in Japan, nobody really knows what is going on in Japanese hospitals. You think that is a shame. You know doctors at big hospitals struggling with patients' treatment have no time to do research. Therefore, research on euthanasia should be conducted with the cooperation of medical schools of leading universities.

The concept of Hospice is not common, because Japanese people have a high regard for conventional acute hospitals with the latest high-tech equipment. A hospice is considered as *the second or a less efficient* health care organization. As a person who studied in Los Angeles for two years, you think hospice should become popular to meet contemporary Japanese patients' growing need to find the best approach for their final days of life.

Mr. Lowell:

You are 85 years old man and live alone. You fell one year ago around your house. You are still in the hospital. Your daughter, Nina, comes to see you once a month or so. Since your daughter chose your present doctor, Dr. Anne Williams, every time you have to communicate with Dr. Williams, you do not feel comfortable.

You are now preparing the topic to be discussed with Nina when she is supposed to show up to your room. You want to order Nina to find a male doctor for you, because you do not like being treated by Dr. Williams at the final stage of your life. You see nothing wrong in asking a doctor about his value system, religious belief, family background, whether or not his father/grandfather or mother/grandmother are doctors, what medical school he graduated from, what he thinks about euthanasia, whether he would leave an order for a nurse to inject intravenous medications to end a patient's life, how to deal with double effect (reducing pain and/or hastening death at the same time), how much he values patient's and/or family members' wishes, and what his number-one priority is in case of conflict between patient's living will and the family members' final decision.

Let's do a summary of all participants' ideas:

Parties	**Mrs. Johnson**	**Dr. Lawrence**	**Dr. Kato**	**Mr. Lowell**
Facts:				
Interests:				
Perceptions:				
Fair reasons:				
Alternatives:				

Have you tried to take a risk in role-playing? If so, how did you act in the role-play? Explain below: I did ....., because

.....

.....

However, ... Next time, I will .....

.....

Lesson 7. On *Pain control*, which is better hospitals or palliative care?

Reading Materials:

#1: Bradley, S. et.al. (ed.), 1980. "Come Up from the Fields, Father." by Walt Whitman in Leaves of Grass:II. New York University Press.

#2. Foley, K. 1991. Jul. "The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide." Journal of Pain and Symptom Management. 6 (5): 289-297.

#3. Farsides, B. 1998. Jun. "Palliative care – a euthanasia-free zone?" Journal of Medical Ethics. 24: 149-150.

#4. "Hospice Care." 1999. Feb. INFORMATION from Focus on the Family.

#5. Bousingen, D. 1998. Oct. 3. "Euthanasia and pain relief discussed in Europe." THE LANCET. 352: 1129.

Objectives:

- Content: Grasp various kinds of pain in patients/their families. Compare the different functions of a hospital and a hospice.
- CCT: Recognize patterns of various kinds of pain.
- Role-play: Seek for alternative treatment to reduce pain.

Brainstorming: Ask students: "What kind of pain have you experienced? What is socio-psychological pain for you? If you happen to see someone lying on the ground, are you the person to approach that person for help? If not, WHY?"

Questions:

#1. On reading #1, fill out the following chart. The lines, 1 & 2 and 12 & 13, seem to be related each other. Note: Pete is their son's name.

Utterance:	Line 1	Line 2
1) from who:	_____	_____
2) to whom:	_____	_____
3) words spoken	_____	_____

Action:	Line 12	Line 13
1) who acts:	_____	_____
2) from where:	_____	_____
3) to where:	_____	_____

- Compare the mother's situation with human's normal/healthy daily life-based description.

	Normal routine	under tragic situation
1) clothes	_____	dark/black color
2) meals	_____	_____
3) sleeping	_____	_____
4) attitudes	positive behaviors	_____
5) other aspects	_____	_____

- Ask students: "Describe the pain/suffering you experienced through various characters in this poem."

#2. On Dr. Foley's article, fill in the words from the article.

Nature of pain: (1) _____ pain (acute postoperative or chronic issues)

(2) _____ pain (distress relating to suicide risk)

Lack of knowledge of pain assessment among *health care professionals*:

(1) combined approach: _____

(2) fear of addiction: _____

(3) restriction of health care system: _____

Lack of knowledge of pain management among *patients and people:*

(1) How to educate patients/family? _____

(2) How does pain relate to patient's quality of life?

_____

(3) How to enlighten general public? _____

#3. On reading #3, think on your own the following issues and then discuss as a whole class: (1) Any addition to WHO's definition of palliative care?; (2) How would Farsides connect *passive euthanasia* with patients' options?; (3) How much is *active euthanasia* overlapped with patients' right?; and (4) How do patients' options/rights parallel with the ethical basis of palliative care which is expected to create palliative care-oriented *self internal-moral debate?*

#4. If a patient is scheduled to move from a hospital to a palliative care/hospice, what assistance can the staff of the two organizations perform to ensure a smooth transition for the patient?

Role-play #7. Who can give *Hope* to seriously ill patients?

On the above issue, all participants mentioned below will exchange their ideas.

Dr. Christen Lincoln: You are Dr. Christen Lincoln working at a hospice near your house for 25 years. Your life-long question is "If pain medication were adequately dispensed, would nobody want to die?" Your everyday interaction with your patients contributes to re-thinking and then changing the above question to your belief. Knowing about hospice/palliative care (originally from Greek *Palian* or cloak/cover) and hospice's founder, Dr. Cecily Saunders, once a social worker, a nurse and finally a doctor being still alive in England, you are interested in her modern hospice techniques expressed in *covering without curing.* You also remember Dr. Saunders said, "Euthanasia is completely **un**necessary now that sophisticated drug administration can control most pain. Because fear as well as pain makes people rush to euthanasia."

You know the goal of hospice is to deal with struggling patients' transition between life and death, by focusing on quality of life, personal dignity, self-control, and choice, whereas, euthanasia movement is for different people with varying problems.

As a doctor, the most crucial point is how to solve the *double effect* between (1) reducing pain and (2) hastening death. Disagreeing with people who think **no** difference of motivation between active/passive euthanasia, you believe *motivation of caregivers*, i.e., wanting to reduce pain and simply killing patients, can make a big difference.

Mr. Matthew Melville: Looking back to your first work at a local bank, right after having graduated from a college, when the Great Depression was marching on, you have worried, since 1990, about becoming *powerless* because of your fear that cancer might catch you tomorrow. You feel isolated even with your wife or better-half, Frances, because she has lost memories of your mutual good old days. Even though you are surrounded by your sons, daughters, and their kids, you feel lonely because, after all, you have to die alone!

In your everyday interaction with others, you notice your age influencing your behavior or choice of strategy in interpersonal negotiation. You hesitate to make demands on others, even your family members. You tend to use a lower strategy or lukewarm expressions whenever you want to ask someone for help. Your self-esteem is weakened further by your grandchildren's unwillingness to listen to you.

Last month, your doctor said, "You need to find a hospice. Remember you have had a heart attack once a week. The tendency would increase unless you find good health care. As the worst scenario, your heart may go on strike." You want to find a hospice in which *total pain management* with doctors, nurses, psychiatrists, and counselors will be efficiently implemented.

Mrs. Nora Wilson:

You, Mrs. Wilson, have suffered from complications of cancer. Therefore, you have been hospitalized for two years. A couple of minutes ago, your doctor came and said, "I have nothing to further help you." Having heard the expression out of the blue from your doctor whom you totally believe, you suddenly felt as if you were in the bottom of hell. You ask yourself, "What is the next step to take right now?" You recall the family as a surrogate decision maker written in a book on the end of life. You just recognize how much you have missed the word, *family*, since 1980 when your parents passed away. As you have no sisters/brothers, you need to find someone who could work as a court-appointed guardian. Another problem is how to get information on any hospice care around your home.

While flipping through the pages of *The Boston Globe*, you have just noticed an advertisement of a hospice in which the name of Dr. Lincoln was printed as the chief physician. You will call Dr. Lincoln to see whether she could accept you as one of her patients. You want to find a doctor who could adjust himself/herself by coming down to the patient's level to deal with fears, worries, concerns, and suffering, and then try to address patient's unspoken *chaos* as if it were his/her own.

Ms. Kate O'Conner: You're Kate and a friend of Mrs. Wilson for a long time. You, a registered nurse, have been working for a hospice for 25 years. You know patients have to experience various kinds of pain, i.e., psychological pain, cultural pain, and spiritual pain, except for physical pain. Today, you're going to see her in the hospital. You want to discuss her alternatives, such as, hospice care providing skilled nursing care and pain management. Even though a hospice provides *no treatment*, patients will feel comfortable in a loving environment which is very different from acute hospitals with their conventional restrictions. When suffering becomes unbearable, a hospice can give patients appropriate treatment based purely on humanitarian reasons.

You wish to tell her about Dr. Lincoln who always tells her new patients discharged by hospitals, "Now we can do something for you." You must tell her Dr. Lincoln accepts to give drugs to her patients to reduce pain which may hasten death. Dr. Lincoln agrees with Dr. K. Foley who believes that doctors who do not provide patients with such medicine should be sued. You tell your friend, "Dr. Lincoln believes patients should make choices on their total pain control by antibiotics."

In your hospice, doctors as a *team* work effectively to *share* the same problems together at debriefing time. Doctors believe the time spent with family members on the discussion of a patient's changing situation is extremely important to figure out how much family members really care in the processes of losing their loved one, while they get mad at God who cannot take their loved one's pain, even though they acknowledge God exists.

Try to fill out the form below individually and then discuss in your group later on.

Parties **Dr. Lincoln** **Mr. Melville** **Mrs. Wilson** **Ms. O'conner**

What was your priority in this role-play?

Interests: ....

Fair reasons:

Perceptions:

Alternatives:

How do you evaluate yourself in a role-play? Your satisfactory level might be, i.e., 50%, 30% or 60%. Write a paragraph below on your evaluation:

.....

.....

And then share in a whole class.

Lesson 8. How does legalization of euthanasia relate to ethics?

Reading materials:

#1. Mariner, W. 1997. Dec. "Health Law and Ethics." American Journal of Public Health. 87 (12): 2058-2062.

#2. Bergman, B. 1998. Mar. 9. "The Final Hours." MACLEAN'S: 46-49.

#3. Ryan. C. 1998. "Pulling up the runaway: the effect of new evidence on euthanasia's slippery slope." Journal of Medical Ethics. 24: 341-344.

#4. Molotsky, I. 1998. Oct. 2. "Wife Wins Right-to-Die Case; Then a Governor Challenges It." The New York Times: A26.

#5. "Virginia's Top Court Rejects Appeal in Right-to-Die Case." 1998. Oct. 3. The New York Times: A13.

#6. "Subject of a Right-to-Die Legal Fight Dies." 1998. Oct. 10. The New York Times: A9.

#7. "Virginia court allows removal of feeding tube." 1998. Oct. 16. National Catholic Reporter.

Objectives:

- Content: How has law influenced ethics of a person in various situations?

- CCT: What kind of request people do on the verge of ethics and law.

- Role-play: Defer judgment on others' roles, while clearly acting your role.

Brainstorming: Ask students: "When did you first recognize that law controls your life? How would law be revised to keep both: a person's rights and others' rights in a society? When should law be intervened to settle controversial problems in a society? How has Japanese Supreme Court done for euthanasia?"

Questions:

#1. On reading #1, Jot down five legitimate-state-interests in Washington's laws served in a rational way and add your comments as well.

State-interests	your comments
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

- Explain the two causes of death:

(1) _____ and (2) _____.

- What would be creative alternatives for *3 days* of life in *un*necessary pain?
- Why is suicide not a crime in the U.S. and what are the Supreme Court's decisions?

Your answer would be: Because _____.
I think _____.

#2. On reading #2, fill out the form below:

	Areas legally further investigated	vs.	your comments
What the doctor did:	_____		_____
What the nurses did:	_____		_____
The ways family members treated:	_____		_____

#3. On reading #3, exchange your ideas in your group on: (1) Why does Ryan *not* agree with people who fear about the slippery slope of involuntary euthanasia? and (2) your idea on how to improve the Remmelink study for future research.

Fill in the chart below:

	Australia vs. the Netherlands	Japanese systems
1) Similarity of health systems:		
2) Differences in culture:		
3) Other factors *you* want to add:		

- How does paradoxical effect of euthanasia relate to Ryan's intuition?

#4. On Virginia's case, fill out the words below:

	Description reported	**Your comments**
Mrs. Michele Finn's view:	_____	_____
Mr. Finn's brother, John's view:	_____	_____
Judge Hoss's argument	_____	_____
Gov. Gilmore 3rd :	_____	_____
State Supreme Court:	_____	_____

- What have you learned from this case? _____

- Can you find any similar case in Japan? _____

Role-play #8. Are we all POL (Prisoners of Law)?

The following three people will find out how a government policy relates to ordinary people's decision making at the end of life.

Mrs. Jefferson: You're a former teacher at a kindergarten. Last week, your doctor said as the result of your annual health check up, "I've found you have breast cancer." You have no symptoms, but you need to sort the problem out. You have been thinking of your birthday. You will turn 60 in May 1999. "Who am I? What have I done as a career? Nothing much except for raising two kids. Oh, my husband ... somehow we've been living together. Honestly speaking, my point is *Who* benefits if I die slowly. If it benefits my children or husband, I'd be willing. No point in a slow death, I think. Even though my family is nearby, my wish of not keeping my life by any machines should be highly regarded. I hate to go through situations written in some articles in The New York Times in which the family deferred to the patient's decision."

You don't understand why suicide is legal in the U.S., but assisted suicide is not. Comparing natural death in the past with recent high-tech life prolonging machines, you wonder if turning off the machine is illegal. When someone faces *no quality of life left*, what alternatives should s/he choose? How can law find the dividing line in a society where no right and/or wrong exists? You wonder if there is an exception of old laws which would be still appropriate in 1999. If so, let's keep that law only and any other *archaic* laws/regulations should be replaced.

Mr. Douglass: You, Mr. Douglass, have more than 45 years as a social worker in downtown and East Side of Chicago. You have *sympathy* for mercy killers, because they helped patients out of only *compassion.* Your question is, "Should all of us experience terrible days just to obey the present law or regulations? What is the smartest way not simply awaiting the inevitable end?"

Your next question is, "What's wrong to think about alternatives?" Such as, a living will as an advance declaration of one's wish and a Durable Power of Attorney to solve legal/ethical troubles by empowering voiceless patients at their final stage. You believe that a living will have two functions: (1) to make sure patients stay in control and (2) to protect doctors, nurses, and other medical professionals from lawsuits by relatives after one's death. You know any mal-practice suits against doctors must be filed in the U.S. within three years after death. You also recognize the *Cultural illusion* of *autonomy-minded Americans* who tend to believe that writing a living will is good enough for their final stage. However, doctors, in reality, rarely pay attention to such written documents, and, to make the situation worse, each person's final stage tends to become complex and does not clearly correspond with/match the content of the will. Or there still remains room for interpretation of the will. In reality, some responsible person in a family or a friend must check whether or not the will was duly executed as the patient originally requested.

Mrs. Sato: You are a Japanese widow of Mr. Sato who passed away 10 year ago from cancer at the age of 85. You feel that Japanese government policy has always been behind people's changing thoughts. Japanese do not openly talk about personal matters, except for very close friends. Therefore, to claim your rights against laws is extremely unusual. If you mention your financial problems, others tend to assume you are a financially ill prepared. People are prone to stigmatize and/or look down you as a shameful person, and no further contact would follow. On the contrary, if you tell about doctors in your family/relatives, your doctor will take good care of you, because you cannot be ignored compared with other patients with no doctors in their family/relatives.

You know in Japan a person actively claiming his rights is called as *green* or *immature,* not knowing that it is futile to devote time and energy to fighting the laws. A saying, "Bigger is better than smaller," applies in every part of your culture, except for transistor radios. People expect college graduates to join a big company. Therefore, some students or active leftists as a minority against the mainstream norms have to change their attitudes just before applying for a big company. The underlying notion is that individuals cannot do anything, except for a company's backup.

Due to your old age, staff in hospitals disregards you. "That's not fair!" Aging is everyone's destination starting from birth. You want to find a government office on euthanasia to prepare for your living will. You want to enjoy individual differences even in Japan by *going ahead* on your own.

Fill in the form below and then discuss in a whole class.

Parties	**Mrs. Jefferson**	**Mr. Douglass**	**Mrs. Saito**

Did you get bored in the middle of a role-play? If so, write below the reasons:

.....

.....

Fair reasons: ....

Perceptions:

Interests: ....

Alternatives:

Did you listen to others' views deeply? If so, Why? .....

.....

If not, what bothered you, while others were speaking? Explain about your disturbing thought.

Lesson 9. What is the current euthanasia-oriented climate in the U.S.?

Reading Materials:

#1. Back, A. et.al. 1996. Mar. 27. "Physician-Assisted Suicide and Euthanasia in Washington State." JAMA. 275 (12): 919-925.

#2. MacDonald, W. 1998. Jan. "Situational Factors and Attitudes Toward Voluntary Euthanasia." Social Science & Medicine. 46 (1): 73-80.

#3. "Oregon Assisted Suicide Law Back in Court." 1999. Jan. 8. The Internet.

#4. Smith, W. 1998. Feb. 23. "Death March." NATIONAL REVIEW. 50 (3): 33-34.

#5. Shapiro, J. 1998. Apr. 6. "Assisted suicide: When physicians hasten death." US NEWS & WORLD REPORT: 27.

#6. Kirk, K. 1998. Aug. "How Oregon's Death with Dignity Act Affects Practice." American Journal of Nursing: 54-55.

#7. "Kevorkian Sentenced to 10 to 25 Years in Prison." 1999. Apr. 14. The New York Times: A1.

Objectives:

- Content: Grasp why the law of states cannot satisfy people's needs.
- CCT: Develop flexibility to seek for alternatives applied in the future.
- Role-play: Create other options, while sharing your empathy with others.

Brainstorming: Ask students: "Have you heard about Oregon State Laws on euthanasia? How would Kevorkian's actions influence you and Japanese ways of thinking on life and death issues?"

Questions:

#1. On reading #1, fill in the chart below:

Patient Concern: Your comments on the research vs. Japanese counterpart

Future loss of control: _____

Being a burden: _____

Being dependent on others: _____

Loss of dignity: _____

#2. On reading #2, write a sentence in each column below.

Your comparative analysis on VE: the U.S. vs. Japan.

Type of assistance: _____

Type of illness: _____

Type of patient: _____

#3. On reading #5, create on your own a final interaction between a dying person and his/her relative and then compare with your partner.

You say: _____.

A dying person would say: _____.

Ask students: "Have you found any different, but an interesting approach taken by your partner on the above interaction? If so, think about the reasons why. Are you going to apply your partner's approach when you do a role-play in the near future?

#4. On reading #6, how can nurses compromise their conflicts between Measure 16 and their personal moral beliefs?

Measure 16: _____.

Their moral belief: _____.

#5. Complete Kevorkian's personal history by choosing the words from a list below:

1920, 1924, 1928, 1945, 1950, 16, 17, 18, Michigan, Washington, California, pathology, physician, surgeon, Washington, D.C., Detroit, San Francisco, Seattle, air force, navy army, 1985, 1988, 1990, 1991, 1993, 1995, 1996, 1997, 3rd, 5th, 7th, 79. 85, 100, March 14, 1998, Latin, Japanese, classic organ, piano.

Dr. Jack Kevorkian was born on May 26, in _____ in Pontiac, _____. He graduated from Pontiac High School in ____ with honors at the age of ____. He did internship in ____ at Henry Ford Hospital in ____. He obtained a medical license in _____. He went to Korea to begin a 15 month stint as an _____ medical office. In 1957, he conducted research in West Germany. In 1970 he moved to _____. In ____, the first person committed suicide with his assistance. In ____, his ____ medical license was revoked after _____ assisted suicide. In ____, Governor of _____ signed law a ban on assisted suicide. As of ____, his lawyer reported that ____ assisted suicides took place by him. He loves to learn _____, and to play _____.

#6. What do you think about the latest article on April 14, 1999, on Jack Kevorkian? Think about on your own and then discuss in your group. Then, share ideas in a whole class by referring to the opinions of Mrs. Youk, his brother, and the judge.

Role-play #9. How can we benefit from Oregon's latest guidelines?

The following four people are sitting in a "Let's talk" room at Pacific University in Portland, Oregon, to talk about the guideline of Oregon's Assisted Suicide.

Dr. Paine: You are a retired medical doctor/professor of the University of Oregon and live alone in Portland, Oregon, since your wife passed away five years ago. Because of your heart problems, you always carry medicine for emergencies. Today, You've just found on the Internet about "Oregon Taxpayers to cover Assisted Suicide." As a Catholic, you really cannot agree to your state's new regulation on euthanasia stated partially below:

> The Oregon Health Services Commission voted 10-1 that taxpayers should be forced to pay for assisted suicides. They decided that lethal doses of prescription drugs should be covered as a medical service for the state's 270,000 low-income residents under the state's health plan.

You think that to offer state-funded suicide, while failing to offer adequate care to rural communities where neither hospice care nor psychiatric care may be available, is unconscionable. This new policy must withstand federal scrutiny, because Medicaid receives federal matching funds.

You believe the crux rooted in euthanasia is "What is the priority of the state to save our life?" Reflecting on Thomas Paine's pamphlet, *Common Sense*, you say to yourself that no such *common sense* exists in 1999 in the U.S., because Americans have twisted their traditional ethical priority and/or values.

Mr. Thoreau: You are Mr. Thoreau, right now a bachelor as you divorced from your wife, Jane, three years ago. You have been a freelance writer in Portland, Oregon. You talk to yourself, "Not only did I try to kill myself several times, but also I traveled a lot in continental Europe in my twenties and thirties. I was interested in European history and archeology. When I recall the time spent in Europe, I honestly think that my true reason for visiting European countries was to make me busy in order to avoid suicidal attempts." Since your parents both died after a very long illness, you have tried to become familiarized with death. The more you become conscious of death, the more you realize how precious every second is in the present world.

Having gathered information on legal process of state/federal levels, you know Congress passed law in April, 1998, forbidding federal money from being used to cover assisted suicide. But that does not prevent coverage under the Oregon Health Plan, just like abortions not enabled by federal funds are still covered by Oregon's state money. Along with private insurers, except Catholic health plans, Oregon is scheduled to cover lethal prescriptions' costs.

You are a member of the Hemlock Society and agree with their credo below:

#1. A dying person should not have to do it alone. Isolation at such a time is an inhuman experience.
#2. Individuals must personally act with caution and discretion when someone supplies the means, i.e., drugs or plastic bag, etc.

Your present question is: How would the latest Oregon's guidebook help prepare your version of the final exit?

Mr. Knight and his son, Ralph: You are Mr. Knight living in Seattle, Washington with your son, Ralph. Your wife, Emily, has been hospitalized for two years for lung cancer. You ventured to call her doctor up and told your frank impression of your wife. Her doctor said, "Seriously speaking, I must accept your wise insight, because your wife has just got pneumonia." When you casually asked Emily, "Who would want to be hospitalized for a long time?" Emily said, "If I cannot live more than 6 months, I really want to die naturally at home. Please listen to my final wish." When you approach Ralph, he said, "Dying? That must not be true! She looks ten years younger than she really is, with her swimming and yoga."

You both determined to take care of her at home. You ordered a new bed, changed the bathroom, and called local hospice to send the brochure called *How to take care of your Loved One At Home*. Emily diminishes day by day. You gradually recognize, "Tomorrow Emily might die." By reflectively evaluating your work for her, you murmur, "How well are we doing?" Even though you are doing well, Emily seems to have lost her consciousness. You, both, argued due to heavily getting tired. You wonder if you can go on. For the first time, you recognize whether she could go on or not. You find yourself considering the act of euthanasia. Ralph said, "Should we go to Oregon?" You said, "Wait a minute. Let's figure out how the latest Oregon's guideline suits Emily's current situation."

To make the outcome of your discussion clear, let's jot down your impression of each participant and then exchange your sheets among your group.

Parties	**Dr. Paine**	**Mr. Thoreau**	**Mr. Knight**	**Ralph**
Who started today's role-play?				
Fair reasons:	.....	.....	.....	.....
Perceptions:				
Interests:				
Alternatives:				

Any consensus reached? If not, what were the obstacles? Discuss within your group and share in a whole class later on,

Lesson 10. What is going on in the Netherlands, Australia, and other countries?

Reading materials:

#1. Sullivan, M. et.al. 1998. Oct. "Beliefs Concerning Death, Dying, and Hastening Death Among Older, Functionally Impaired Dutch Adults: A One-Year Longitudinal Study." JAGS (Journal of the American Geriatrics Society): 1251-1256.

#2. Onwuteaka-Philipsen, B. et.al. 1997. Oct. "Active Voluntary Euthanasia or Physician-Assisted Suicide?" JAGS:1208-1213.

#3. Van Der Maas, P. et.al. 1996. Nov. 28. "Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995." The New England Journal of Medicine: 1699-1705.

#4. Van Der Wal, G. et.al. 1996. Nov. 28. "Evaluation of the Notification Procedure for physician-assisted death in the Netherlands." The New England Journal of Medicine: 1706-1711.

#5. Kissane, D. et.al. 1998. Oct. 3. "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia." THE LANCET. Vol. 352: 1097-1102.

#6. "Austrian moves on euthanasia come at sensitive time." 1998. Mar. 7. THE LANCET. Vol. 351: 734.

Objectives:

- Content: Follow and understand the outcome of research in reading materials.
- CCT: Defer judgment based on comparative analysis of research data.
- Role-play: Explain your empathy to others, and think of alternatives as well.

Brainstorming: Ask students: "What do you know about the Netherlands, except for very beautiful tulip gardens in Amsterdam? Guess which country first started euthanasia."

Note: Show colorful tulips' photos in the Netherlands and a map of Australia.

Questions:

#1 Compare the reading materials on euthanasia/assisted suicide and fill out the words below:

	Dutch patients	American patients
Patients' fear of death vs. religious belief:	_____	_____
Psychiatrists' contribution to patients' treatment:	_____	_____
Patients' Socio-cultural and health status:	_____	_____
Public support:	_____	_____

#2. In reading #2, what different understanding exists: in the Netherlands vs. in the U.S.?

	Netherlands	U.S.A.
Euthanasia:	_____	_____
Physician-assisted suicide	_____	_____
Active voluntary euthanasia	_____	_____

#3. On reading #3, make a paragraph on the issues below comparing 1990 vs. 1995.

1) Patients' gender, age, locale/state of patients: _____.
2) How patient's Explicit Request heard: _____.
3) How Double Effects were controlled: _____.
4) Elements of stopping treatment: _____.
5) Is Slippery slope plausible?: _____.
6) Economic motives: _____.

#4. On reading #4, how will the present guideline of the Netherlands be revised to reveal cases of: (1) physician-assisted death without the patient's explicit request and (2) the belief of death as a private matter between a doctor and a patient?

#5. Create a sentence beginning with "I am impressed..." on the first legalized euthanasia in the *Northern Territory of Australia* and share your views with other peers.

I am impressed .....

.....

#6. What hampers the efforts of lawyers, doctors, and philosophers urging the Austrian government to legalize passive/active euthanasia?

Role-play #10. How would a foreign patient be treated in the Netherlands? The following five people will exchange their views on the Netherlands' applications of euthanasia.

Anyja and Anna: You are **Anyja**. You were born in Holland. However, you are now an American, because you met an American when you attended a conference in Amsterdam 40 years ago. You, a housewife, have been in Boston for 40 years. You are right now in Amsterdam on a two-week trip.

You, **Anna**, are a Dutch woman or a relative of **Anyja**. You have lived in Amsterdam for 50 years since you were in middle school. You have been hospitalized for one year in The Royal Hospital downtown Amsterdam next to the famous Hotel Okura, an affiliate of Hotel Okura in Tokyo next to the Embassy of America in Japan. You have suffered from cancer for a long time.

Today, Anyja, one of Anna's relatives came to see you. You said to her, "Right now, the government controls our everyday life. Euthanasia is widespread with the complicated guidelines for doctors and other people involved. Therefore, we feel scared to meet different doctors, I mean, not our family doctor, but strangers. What if they decide to euthanize us?"

Since you, **Anyja**, studied the history of Christianity in Holland when you were a college student, you recalled Holland was a center of Christianity in the 16th

century. Then you asked **Anna** "Are you a Christian?" **Anna** said, "Yeah, only some of us are Christians." Having heard that, you, **Anyja**, shout, "Wait! Do you mean a few of you?" **Anna** said, "I've got your point! You must admit our society was not exactly the same as what it used to be. Nowadays, you believe it or not, we, Christians, have become a *minority* in our society. Because the latest government statistics show that immigrants from Moslem countries, especially from Turkey, have been increasing in big cities in our country. Therefore, we guess that our religious picture of Holland will be drastically changed in the 21st century."

After having lunch together, you both are right now sitting in the cafeteria of The Royal Hospital to further chat on your *good-old-days*, because **Anyja** will be leaving for Boston next week.

Mr. Mark Baldwin:

You are a pilot of Navy in the U.S. One of your ancestors is James Baldwin, an American writer with lots of short stories, such as, *Nobody knows my name*, stayed in France in his later life.

When you traveled in the Netherlands during your honeymoon, you got involved in a terrible fire when you started to use a rent-a-car in Amsterdam, because the ignition of the motor set off a severe and unexpected explosion. Unfortunately, your just-wed wife died. You were taken to the nearest hospital called The Royal Hospital and admitted in a critical but conscious state with second degree burns over 68 percent of your body. Even after three operations, you are blind by corneal damage, ears are mostly destroyed, and you have severe burns all over your face, upper extremities, body, and legs.

Having recognized your un-recoverable situation, you are determined to die. Or to live happily ever after with your wife in Heaven! You must create your version of death or make your parents become aware of the best strategy to genuinely *save* their loved one's dignity.

Mr. and Mrs. Baldwin:

You, Americans, are the parents of Mr. Mark Baldwin. Out of the blue, you got terrible news from The Royal Hospital in Amsterdam. You lost words and came to Amsterdam yesterday. You are extremely concerned about your son's future as well as his newly-wed wife's death. You, Mrs. Baldwin, know that Mark has been such a stubborn man, he might shout, "Kill me! Or go ahead and do euthanasia!"

After checking the regulations of health care in the Netherlands through the Embassy of Netherlands in the U.S., you, parents, have learned that the Netherlands has an absolute rule against euthanasia for foreign terminally ill patients dumped from other countries.

Since you, Mr. Baldwin, are a medical doctor, you talked with your son's doctor and learned about your son's severe situation. What impressed him most while reading research paper of terminal ill patients in the Netherlands is that in the Netherlands patients are more concerned about their *becoming a burden* on their families than having *unbearable pain*. That is the biggest cultural difference between patients in Netherlands and the U.S. You, Mr. Baldwin, say to yourself, "We, Americans, are selfish, focusing on our pain, without worrying about caregiver's feelings."

You both think each country should solve its own problems, even though we can learn a lot from the Dutch experience because of our living in a global village.

Dr. Yuichi Itoh: You are Dr. Itoh. In Japan, if a father is a doctor, that family tends to raise their children to become doctors. Knowing some families whose grandparents and parents are all doctors have problems raising their children to become doctors, you realize that life is anxious and uncertainty, or life is an ambiguous exercise. In case of successfully making their children become doctors, their sons/daughters newly joined in their medical doctors' community seem to act as the copy of their father/mother in terms of treating their patients. The conversation in that family over meals particularly during dinner relates to their patients' relationship with them from the superficial level to deeper levels, if the specific patient himself or his family has some relationship with other doctors. Since you have been a family doctor for more than 40 years in a small village outside of Tokyo, you have had lots of experiences in how families decide their loved one's treatment depending on their symptoms. For example, a family's head, father or any other male in the family is likely to decide their final decision and then tell you as the consensus of the family. Therefore, you really do not know what was going on in the process of that consensus. However, when you attend annual meetings among doctors, you always have a chance to hear some information of your patients' families. If you summarize the main parts of how your patients struggle with their loved one's treatment, you could easily figure out what are the common behaviors among Japanese patients. The most tragic issue would be lack of communication among family members, because the head of each family wants to maintain their social status, without revealing their own family's inside troubles.

On Euthanasia, Japanese do not want to be treated in a foreign country, because patients are the products of its insular culture so that they hate to be ashamed by the following two kinds (intra- and extra culture) of people: other Japanese people within the homogeneous climate and foreigners.

Just winding up your role-play, fill out the form below on your own, share with your group, and then discuss in a whole class later on.

Parties	**Anyja**	**Anna**	**Mark**	**Mr. & Mrs. Baldwin**	**Dr. Itoh**
Future goals:	……	……	……	……	……
Interests:					
Fair reasons:					
Facts:					
Perceptions:					

What have you learned from various role-plays? Write a paragraph on your own below: Regarding interaction with other members of my group, I think ……

…… When I ventured to talk at first, I recognized that …… On Active listening, I noticed ……

…… For future reference, I'd like to ……

……

And then share in a whole class.

BIBLIOGRAPHY

Ad Hoc Committee of the Harvard Medical School, "Definition of Death" 1968. in Bowie, G., Michaels, M. and Solomon, R (eds.), 1996. Twenty Questions: An Introduction to Philosophy, third edition. Fort Worth: Harcourt Brace.

Ajemian, I. And Mount, B. 1985. The Hospice: Development and Administration. Second Edition. New York. Hemisphere Publishing Corporation.

Alper, P. 1992. Jan. 11. "A Living Will Is a Bloodless Document." The Wall Street Journal.

Anderson, P. 1991. Affairs in Order. Macmillan Publishing Company.

Anderson, W. 1990. REALITY Isn't What It Used to Be. HarperSanFrancisco.

Aquinas. T. in Clark, M. 1995. An Aquinas Reader. New York. Fordham University Press.

Baird, R. and Rosenbaum, S. 1989. Euthanasia: the moral issues. Buffalo, New York. Prometheus Books,

Battin, M. 1994. The Least Worst Death. Oxford. Oxford University Press.

Bender, D. and Leone, B. 1992. Death and Dying. Opposing Viewpoints. Greenhaven Press, Inc. San Diego.

Bender, D. and Leone, B. 1995. Euthanasia. Opposing Viewpoints. Greenhaven Press, Inc. San Diego.

Best, J. and Kahn, J. 1998. Research in Education (Eighth Edition) Allyn and Bacon.

Bohm, D. 1995. Unfolding Meaning: A Weekend of Dialogue with David Bohm. London. Routledge.

Bond, S. 1992. "How Social Conditions Affect Creativity" in Hayes, J. The Complete Problem Solver. Second Edition. Franklin Institute Press.

Bowie, G., Michaels, M. and Solomon, R. (eds.), 1996. Twenty Questions: An Introduction to Philosophy. Third Edition. Harcourt Brace College Publishers. Fort Worth.

Bradley, F. 1962. Ethical Studies. Oxford University Press.

Brody, J. 1989. Sept. 21. "Personal Health." The New York Times.

Brower, V. 1992. "Hospices May Not Provide the Best Care for the Terminally Ill." in Bender, D. and Leone, B. 1992. Death and Dying. Opposing Viewpoints. San Diego. Greenhaven Press, Inc.

Burns, L. and Hunt, I. 1996. The Quality of Death: Euthanasia in Australia. Centre for Applied Philosophy, Flinders University, Adelaide. Australia.

Byham, W. 1992. Zapp! In Education. New York. NY: Ballantine Books.

Byock, I. 1997. Dying Well: The Prospect for Growth at the End of Life. Articles in Professional Journals.

Callahan, D. 1992. Mar./Apr. "When Self-Determination Runs Amok." Hastings Center Report.

Coleman, G. 1989. "Assisted Suicide: An Ethical Prespective." in Baird, R. and Rosenbaum, S. 1989. Euthanasia: the moral issues. Buffalo, New York. Prometheus Books,

Dougherty, C. 1993. Fall. "The Common Good, Terminal Illness, and Euthanasia." Issues in Law & Medicine. Vol. 9, no. 2.

Duda, D. 1987. Coming Home: A Guide to Dying at Home with Dignity. Santa Fe. NM. Aurora Press.

Dworkin, R. 1993. Life's Dominion: an Argument about Abortion, Euthanasia, and Individual Freedom. New York. Alfred A. Knopf.

Eliot, T.S. 1963. Murder in the Cathedral. San Diego. Harcourt Brace Jovanovich, Publishers.

Ellinor, L. and Gerard, G. 1998. Dialogue. John Wiley & sons, Inc. New York.

Evers, J. and Byrne, P. 1990. "Brain Death May Not Determine Death." The Pharos. "Brain Death – Still a Controversy." by Alpha Omega Alpha Honor Medical Society. Vol. 53, No. 4.

Feldhauser, J. and Trefinger, D. 1980. Creative Thinking and Problem Solving in Gifted Education. Kendell/Hunt Pub. Co.

Fisher, R. and Ury, W. 1991. Getting to YES. Penguin Books.

Fletcher, J. 1989. "Sanctity of Life versus Quality of Life." in Baird, R. and Rosenbaum, S. 1989. Euthanasia: the moral issues. Buffalo, New York. Prometheus Books,

Frame, D. (translated). 1957. The Complete Works of Montaigne. Stanford University Press.

Freire, P. 1993. Pedagogy of the oppressed. The Continuum Publishing Company, New York.

Gaarder, J. 1996. Sophie's World. Berkley Books, New York.

Gallo, D. 1987. "Empathy, Reason, and Imagination: the Impact of Their Relationship on Education," in Thinking by Perkins, Bishop, and Lochhead (Eds.) Hillsdale, N.J. Erlbaum.

Gardner, H. 1993. Multiple Intelligences: the theory in practice. New York. BasicBooks.

Gaylin, W. "Harvesting the Dead." in Bowie, G., Michaels, M. and Solomon, R (eds.), 1996. Twenty Questions: An Introduction to Philosophy, third edition. Fort Worth: Harcourt Brace.

Girden, E. 1996. Evaluating Research Articles from Start to Finish. Sage Publications.

Goleman, D. 1995. Emotional Intelligence. New York. Bantam Books.

Grice, P. 1969. "Utterer's Meaning and Intentions." Philosophical Review.

Grimstad, J. 1991. June. "Proposals to Treat the Unconscious as Corpses." By Julie Grimstad of the Center for the Rights of the Terminally Ill, Hurst, Texas.

Gruber, H. and Wallace, D. 1989. Creative People at Work. Oxford University Press.

Hazlitt, W. (ed.) 1952. The Essays. The University of Chicago.

Hicks, N. 1998, April. "The Quality of Death: Euthanasia in Australia." Journal of Medical Ethics: 140-141

Honeyman, C. 1990. January. "In Practice." Negotiation Journal. 23-36.

Humber, J. 1991. Spring. "Statutory Criteria for Determining Human Death." Mercer Law Review.

Humphry, D. 1978. Jean's Way. New York. Quartet Books.

Humphry, D. 1991. Final Exit. Eugene, Oregon. The Hemlock Society.

Iggers, J. 1998. Good News, Bad News. Westview Press. Colorado.

Kearns, C. 1994. "Religion, literature, and society in the work of T.S. Eliot." in Moody, D. (ed.) The Cambridge Companion to T. S. Eliot. Cambridge University Press.

Kelly, D. 1992. Sep./Oct. "If, When, and How to Die: Difficult Personal and Family Decisions." The Catholic World.

Kevorkian, J. 1994. Current Biography Yearbook.

Kjellstrand, C. 1992. Jan. 1. "Who Should Decide About Your Death?" Journal of the American Medical Association. Vol. 267, no. 1: 104-105.

Kodish, B. 1998. Summer. "Ethics: A general semantics perspective." Et Cetera: 130-139.

Kohlberg, L. 1983. Moral Stages: A Current Formulation and a Response to Critics. S. Karger. KARGER.

Kohn, A. 1990. The Brighter Side of Human Nature. New York. Basic Books, Inc.

Koops, C. 1989. "The Case of Karen Quinlan" in Baird, R. and Rosenbaum, S.1989. Euthanasia: the moral issues. Buttalo, New York.Prometheus Books.

Koops, C. 1989. "The Right to Die: The Moral Dilemmas." in Baird, R. and Rosenbaum, S. 1989. Euthanasia: the moral issues. Buffalo, New York. Prometheus Books.

Larson, E. and Amundsen, D. 1998. A Different Death: Euthanasia & the ChristianTradition. Downers Grove, Illinois. InterVarsity Press.

Lax, D. and Sebenius, J. 1986. The Manager as Negotiator. The Free Press. New York.

Leo, J. 1994. May 16. "Assisted Suicide's Slippery Slope." US News & World Report.

Lessenberry, J. 1994. Aug. "The Virtue of Choice." The World & I. Washington Times Corporation.

Lorch, Jr. R. and O'Brien, E. 1994. Source of Coherence in Reading. Erlbaum Associates. Hillsdale. N.J.

Marshall, S. 1995. Schemas in Problem Solving. Cambridge University Press.

Matlin, M. 1998. Cognition. Fourth Edition. New York. Harcourt Brace Publishers.

May, W. 1996. Testing the Medical Covenant: Active Euthanasia and Health Care Reform. Washington and Lee University, Lexington.

McCord, W. 1993. Jan./Feb. "Death with Dignity." The Humanist.

Montaigne, M. in Frame, D. 1957. The Complete Works of Montaigne. Stanford University.

Moore, C. 1986. The Mediation Process. Jossey-Bass Publishers, San Francisco.

More, L. and Milligan, M. 1994. The Empathic Practitioner. New Brunswick, NJ, Rutgers University Press.

Moroney, C. 1995. "Physicians Should Not Assist in Euthanasia." in Bender, D. and Leone, B. 1995. Euthanasia. Opposing Viewpoints. Greenhaven Press, Inc. San Diego.

Moroney, E. 1992. Nov. 21. "Three Choices for Death." America.

Nagel, T. 1996. "Death" in Bowie, G., Michaels, M. and Solomon, R (eds.), 1996. Twenty Questions: An Introduction to Philosophy. Third edition. Harcourt Brace College Publishers. Fort Worth.

Newberry, S. 1996. Teaching as a Performing Art. ED420-344. Silver Spring, Maryland. AIIM (Association for Information and Image Management).

Newton, M. 1997. Journey of Souls. Llewellyn Publications, St. Paul, Minnesota.

Nichols, M. 1995. The Lost Art of Listening. The Guilford Press. New York.

Nolan, T. 1996. Learning Styles. Speaker notes from in-Service Day. St. Petersburg Junior College.

Norris, S. and Ennis, R. 1989. Evaluating Critical Thinking. Midwest Publications.

Nuland, S. 1996. "How We Die." in Bowie, G., Michaels, M. and Solomon, R (eds.), 1996. Twenty Questions: An Introduction to Philosophy. Third Edition. Harcourt Brace College Publishers. Fort Worth.

Orlowski, J. 1990. Jan./Feb. "Development of Policies on Brain Death, Care of the Hopelessly ill, and Do Not Resuscinate." Cleveland Clinic Journal of Medicine: 57:1

Orr, D. 1992. Ecological Literacy. State University of New York Press.

Pellowe, J. 1986. "Hearers' Intentions." In McGregor, G. and White, R. (eds.), The Art of Listening. London. Croom Helm.

Plato. "The Death of Socrates" in Bowie, G., Michaels, M. and Solomon, R (eds.), 1996. Twenty Questions: An Introduction to Philosophy. Third Edition. Harcourt Brace College Publishers. Fort Worth.

Pridonoff, J. 1994. Aug 29. "Fear of Suffering Outweighs Death." Insight on the News.

Quill, T. 1994. July 23. "The Care of Last Resort." The New York Times.

Rachels, J. 1996. "Active and Passive Euthanasia." in Bowie, G., Michaels, M. and Solomon, R (eds.), 1996. Twenty Questions: An Introduction to Philosophy. Third Edition. Harcourt Brace College Publishers. Fort Worth.

Raiffa, H. 1982. The Art and Science of Negotiation. Harvard University Press. Cambridge, Massachusetts.

Reeder, J. 1996. Killing and Saving: Abortion, Hunger, and War. Pennsylvania State University Press.

Reich, R. 1991. The work of Nations: preparing ourselves for 21st century capitalism. Alfred Knopf.

Rogers, C. 1961. On Becoming a Person. Cambridge, Massachusetts. The Riverside Press.

Schraw, G. and Bruning, R. 1996. Jul./Aug./Sept. "Readers' implicit models of reading." Reading Research Quarterly. 31. 3: 290- 305.

Shapiro, R. 1990. "The Case of L.W.: An Argument for a Permanent Vegetative State Treatment Statute." Ohio State Law Journal. 439.

Shils, E. 1968. "The Sanctity of Life." in Laggy, D. (Ed.) Life or Death: ethics and Options.

Shor, I. 1991. Empowering Education. New York State University.

Singer, P. 1981. The Expanding Circle: ethics and sociobiology. Toronto. McGraw-Hill Ryerson Ltd.

Singer, P. 1998. Ethics into Action. Lanham, Maryland. Rowman and Littlefield Publishers, Inc.

Singer, P. 1979, First Edition and 1993, Second Edition. Practical Ethics. Cambridge. Cambridge University Press.

Skinner, B. 1971. Beyond freedom and dignity. New York. Knopf.

Steinbock, B. 1996. "The Intentional Termination of Life." in Bowie, G., Michaels, M. and Solomon, R (eds.), 1996. Twenty Questions: An Introduction to Philosophy. Third edition. Fort Worth: Harcourt Brace.

Sullivan, T. 1989. "Active and Passive Euthanasia: An Impertinent Distinction?" in Baird, R. and Rosenbaum, S.1989. Euthanasia: the moral issues. Buttalo, New York. Prometheus Books.

Taylor, P. 1994. Aug. "Dying with Dignity." Sojourners.

Teays, W. 1996. Second Thoughts. Mayfield.

Thomas, L. 1992. Jan. "Living Will Could Let You Down." Hemlock Quarterly.

Thomasma, D. and Graber, G. 1990. Euthanasia toward an ethical social policy. New York. Continuum.

Tishman, S., Perkins, D., and Jay, E. 1995. The Thinking Classroom: Learning and Teaching in a Culture of Thinking. Allyn and Bacon. Boston.

Tolstoy, L. 1960. The Death of Ivan Ilyich and Other Stories. translated Rosemary Edmonds. New York. Penguin.

Ury, W. 1993. Getting Past NO. Bantam Books, New York.

VanDeVeer, D. and Regan, T. 1987. "Health Care Ethics." (Philadelphia: Temple University) in Battin, M. 1994. The Least Worst Death. Oxford. Oxford University Press.

Veatch, R. 1989. Death, Dying, and the Biological Revolution. Yale University.

Volicer, L. 1994. "Impact of Special Care Unit for Patients with Advanced Alzheimer's Disease on Patients' Discomfort and Costs." JAGS. 42:597-603.

Volicer, L. 1997. Sept./Oct. "Goals of care in advanced dementia: Comfort, dignity, and psychological well-being." American Journal of Alzheimer's Disease. 196-197.

Vollert, C., Kendzierski, L, and Byrne, P. 1964. On the eternity of the world. Milwaukee, Wis. Merquette University Press.

Voulo, R. 1991. The "Living Will." The American Life League.

Watzlawick, P. 1978. The Language of Change. New York. BasicBooks.

Wilson, E. 1975. Sociobiology: The New Synthesis. The Belknap Press of Harvard University Press.

Winters, P. 1997. Death & Dying. Opposing Viewpoints Series. Greenhaven Press Inc.

Yeats, W. 1924. "The Second Coming." In Finneran, R. (ed.) The Poems of W. B. Yeats: A New Edition. New York. Macmillan Publishing Company.

Young, E. 1989. "Assisted Suicide." in Baird, R. and Rosenbaum, S. 1989. Euthanasia: the moral issues. Buffalo, New York. Prometheus Books,